



# LGBT Health in NYC: Providing comprehensive preventive health care for sexual and gender minority (SGM) patients\*

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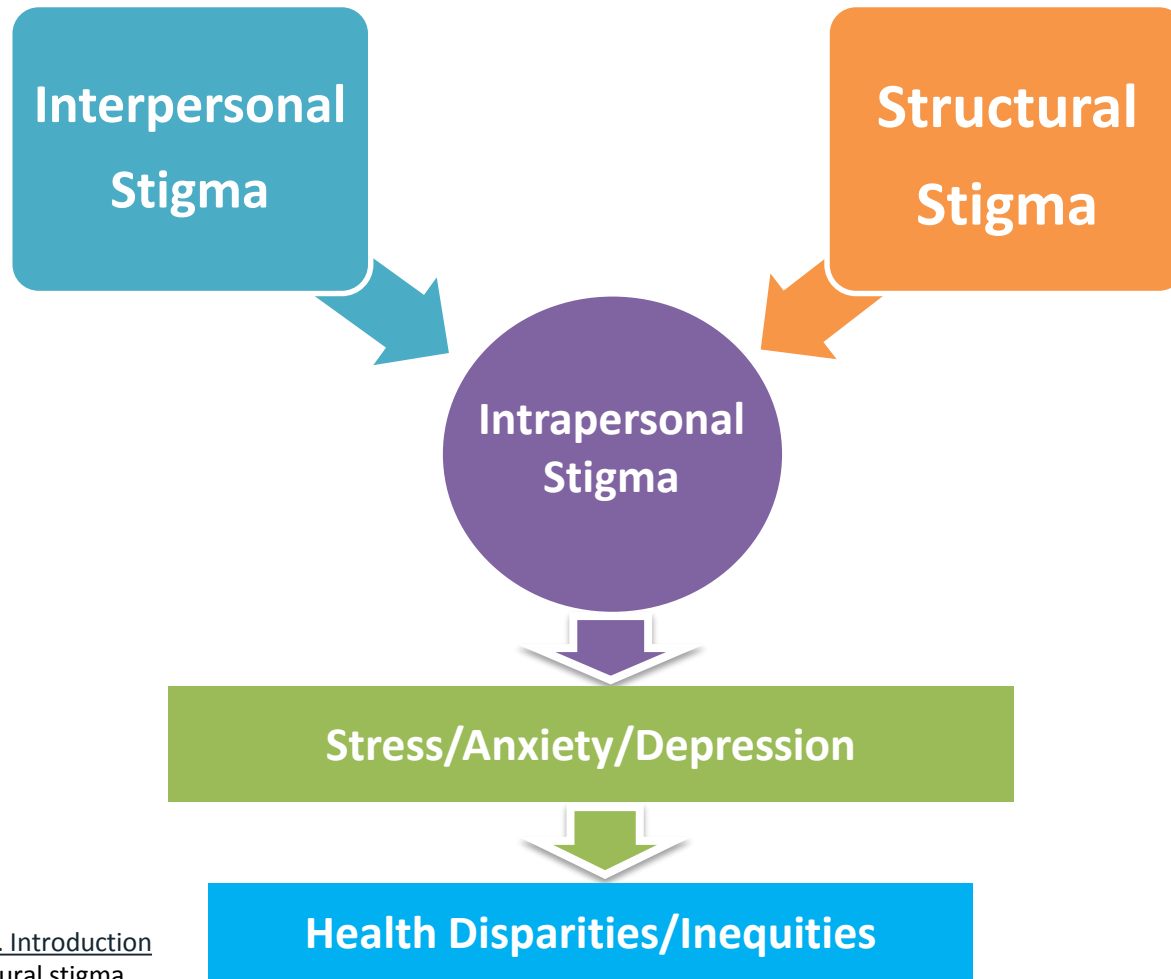
*\*presentation adapted with permission from The Fenway Institute*

# Outline

- Stigma among LGBT persons & terminology
- Sexual health among LGBT populations
- Substance use and mental health
- Disparities in cancer screening
- Addressing barriers
- NYC's Bare it All initiative



# Stigma, Discrimination, and Health



Hatzenbuehler, ML, Link, BG. Introduction to the special issue on structural stigma and health. Soc Sci Med 2014 Feb;103:1-6. doi: 10.1016

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# Effects of Stigma on Health

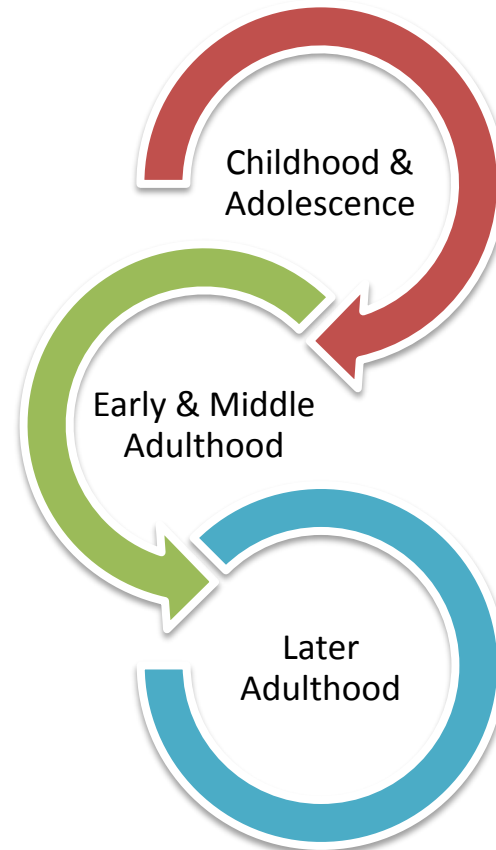
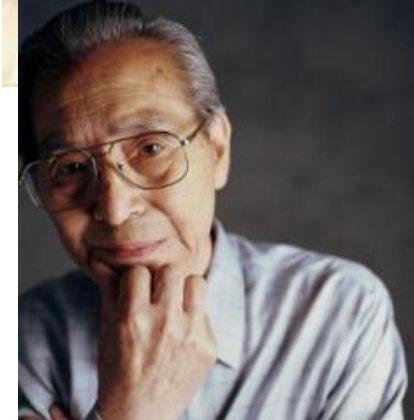
- Internalized homophobia, experiencing discrimination, and expectations of rejection were associated with HIV risk behavior (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008)
- Enacted and anticipated stigma resulted in an approximately 40% increase in delaying needed urgent and preventive care in a sample of 2,578 transmasculine people (Reisner et al. 2015)

## Citations:

- Hatzenbuehler, Mark L., Susan Nolen-Hoeksema, and Sarah J. Erickson. "Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: results from a prospective study of bereaved gay men." *Health Psychology* 27.4 (2008): 455.
- Reisner, Sari L., et al. "Substance use to cope with stigma in healthcare among US female-to-male trans masculine adults." *LGBT health* 2.4 (2015): 324-332.



# Health Issues Throughout the Life Course



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# LGBT Disparities: Healthy People 2020

- LGBT youth
  - 2 to 3 times more likely to attempt suicide
  - More likely to be homeless (20-40% are LGBT)
  - Risk of HIV, STD's
- MSM are at higher risk of HIV/STIs, especially among communities of color
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use
- Lesbians are less likely to access cancer screening services

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# LGBT Disparities: Healthy People 2020

- Transgender individuals experience a high prevalence of HIV/STIs, victimization, mental health issues, and suicide
  - They are also less likely to have health insurance than heterosexual or LGB individuals
- Elderly LGBT individuals face additional barriers to health because of isolation, fewer family supports, and a lack of social and support services

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# Sexual Orientation and Gender Identity are Not the Same

- All people have a sexual orientation and gender identity
  - How people identify can change
  - Terminology varies
- Gender Identity ≠ Sexual Orientation



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# Sexual Orientation

- Sexual orientation: how a person identifies their physical and emotional attraction to others
- Desire
- Behavior:
  - Men who have sex with men-MSM (MSMW)
  - Women who have sex with women-WSW (WSWM)
- Identity:
  - Straight, gay, lesbian, bisexual, queer—something else

## Dimensions of Sexual Orientation:



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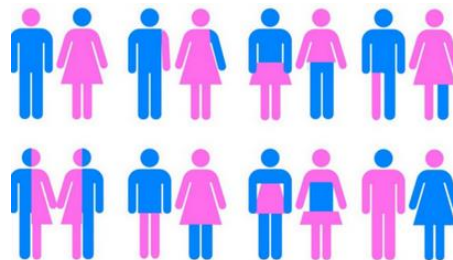
# Gender Identity and Gender Expression

- Gender identity

- A person's internal sense of their gender (do I consider myself male, female, both, neither?)
- All people have a gender identity

- Gender expression

- How one presents oneself via behavior, mannerisms, speech patterns, dress, hairstyle, etc.
- May be on a spectrum



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# The T in LGBT: Transgender

- Gender identity or expression not congruent with sex assigned at birth
- Gender identity is increasingly described as being on a spectrum
- Terminology
  - Transgender woman, trans woman, male to female (MTF)
  - Transgender man, trans man, female to male (FTM)
  - Non-binary, genderqueer
  - Transfeminine, transmasculine

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# Reviewing Terminology

## **Sexual Orientation**

- Whom you are physically and emotionally attracted to
- Whom you have sex with
- How you identify your sexuality

## **Gender Identity**

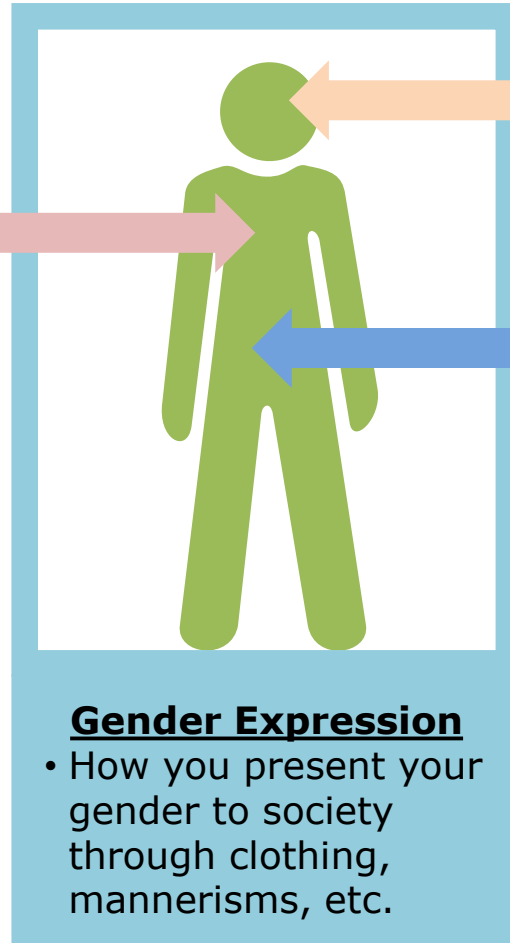
- What your internal sense tells you your gender is

## **Sex**

- Refers to the presence of specific anatomy. Also may be referred to as 'Sex Assigned at Birth'

## **Gender Expression**

- How you present your gender to society through clothing, mannerisms, etc.



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# Discomfort as a Barrier

“Ironically, it may require greater intimacy to discuss sex than to engage in it.”

*The Hidden Epidemic*  
Institute of Medicine, 1997

Ask Screen Intervene

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# Taking a History of Sexual Health

- The core comprehensive history for LGBT patients is the same as for all patients (keeping in mind unique health risks and issues of LGBT populations)
- Get to know your patient as a person (e.g., partners, children, jobs, living circumstances)
- Use inclusive and neutral language
- For all patients
  - Make it routine
  - Make no assumptions
  - Put in context and assure confidentiality

# Avoiding Assumptions

- You cannot assume someone's gender or sexual orientation based on how they look or sound
- How a person identifies their sexual orientation does not always tell you who they have sex with or what kind of sex they engage in, and vice-versa
- Listen to how people describe their own identities and partners--use the same terms, if comfortable
- Avoid assuming gender or sexual orientation with new patients:
  - *Instead of:* “How may I help you, sir?”
  - *Say:* “How may I help you?”

# Preferred Name and Pronouns

- It is important to use the patient's preferred name and pronouns when talking about a patient.
  - For example, most transgender women want you to say “she” or “her” when talking about them. Trans men generally prefer “he” or “his.”
  - Some people may use words or pronouns that are unfamiliar to you. Pronouns such as "zie" or "they" are sometimes used by people who do not identify with the gender binary of she/he.





# Keeping Up with Terminology

- **Queer** – traditionally an insult. However, some people (especially youth) use this term with pride to identify their sexual orientation as non-heterosexual.
- **Genderqueer** or **gender fluid** – used by some youth to describe their gender identity and expression as both male and female, or neither male or female. Also described as rejecting the gender binary.
- **No labels** – Some do not like to use any terms.

# Keeping Up with Terminology

Avoid these Outdated Terms	Consider these Terms Instead
Homosexual	Gay, lesbian, bisexual, or LGBT
Transvestite; Transgendered	Transgender
Sexual preference; Lifestyle choice	Sexual orientation

# Keeping Up with Terminology

- Obvious “don’ts” include:
  - Use of any disrespectful language
  - Gossiping about a patient’s appearance or behavior
  - Saying things about someone not necessary for their care
    - “You look great; you look like a real woman/ real man”
    - “You are so pretty; I cannot believe you are a lesbian”

# Putting What You Learn into Practice...

- If you are unsure about a patient's preferred name or pronoun
  - *"I would like be respectful—what name and pronoun would you like me to use?"*
- If a patient's name doesn't match insurance or medical records
  - *"Could your chart/insurance be under a different name?"*
  - *"What is the name on your insurance?"*
- If you accidentally use the wrong term or pronoun
  - *"I'm sorry. I didn't mean to be disrespectful."*

# Sexual Health among LGBT populations

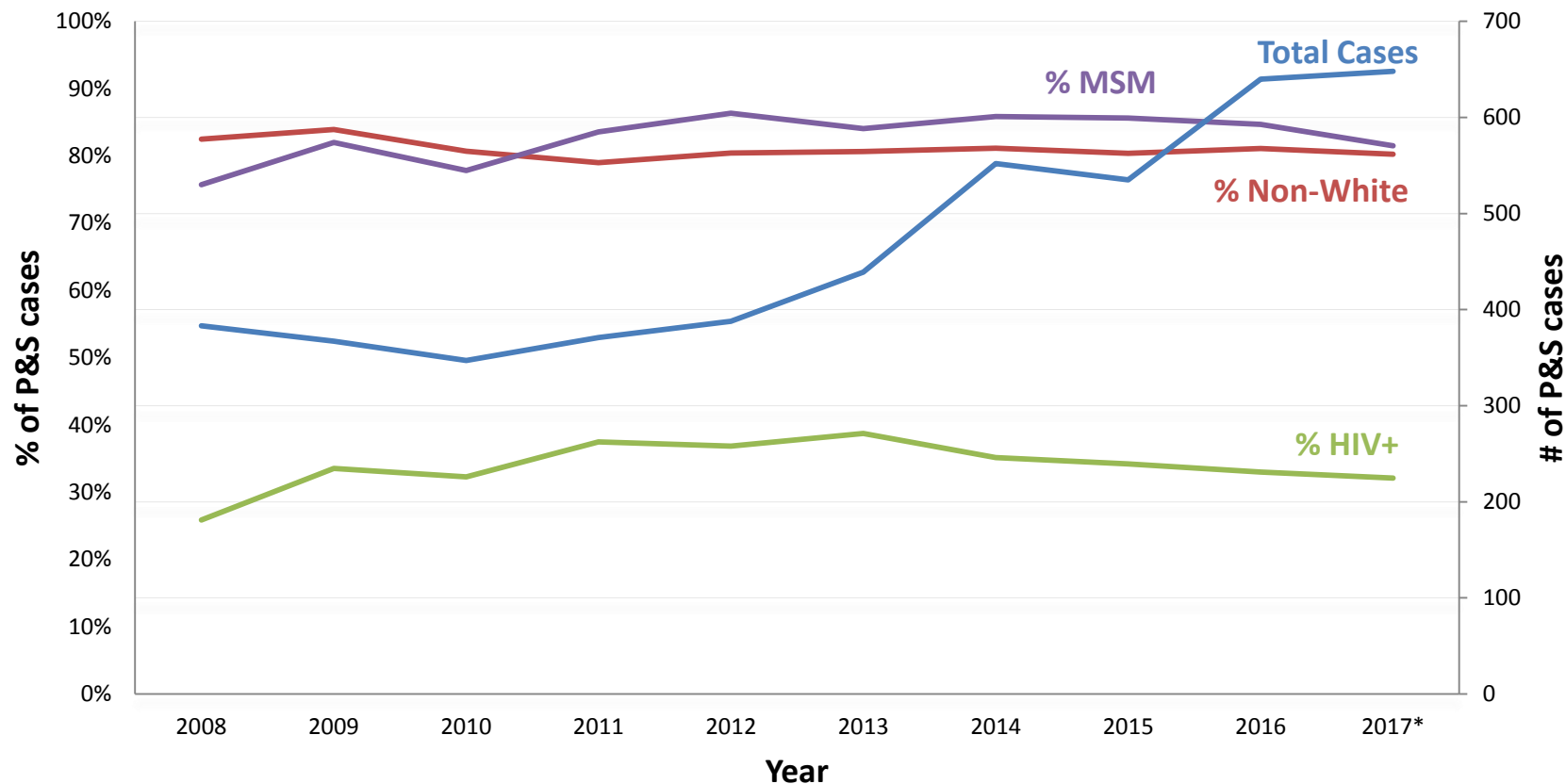


# Multifactorial Nature of STI Risk

- **Individual behavior:** Number of partners/time
- **Biology**
  - Specific sex acts associated with different STIs
  - Particularly, anal intercourse ↑ susceptibility to HIV, other STIs
  - Role versatility: receptive can be insertive
- **Networks**
  - HIV/STIs per contact risk ↑ in high prevalence settings
  - Assortative mixing in sub-groups, e.g. racial/ethnic minorities
  - Sexualized venues, e.g. bathhouses, social media, sex work
- **Structural/Societal**
  - Homophobia, bullying leads to early developmental stress, depression, lack of self-efficacy, and subsequent risk
  - Criminalization and discrimination in health care settings impede disclosure and receipt of timely health services



# P&S syphilis diagnosed among male and transgender<sup>1,2</sup> patients with clinician visits to NYC Sexual Health Clinics, 2008-2017\*

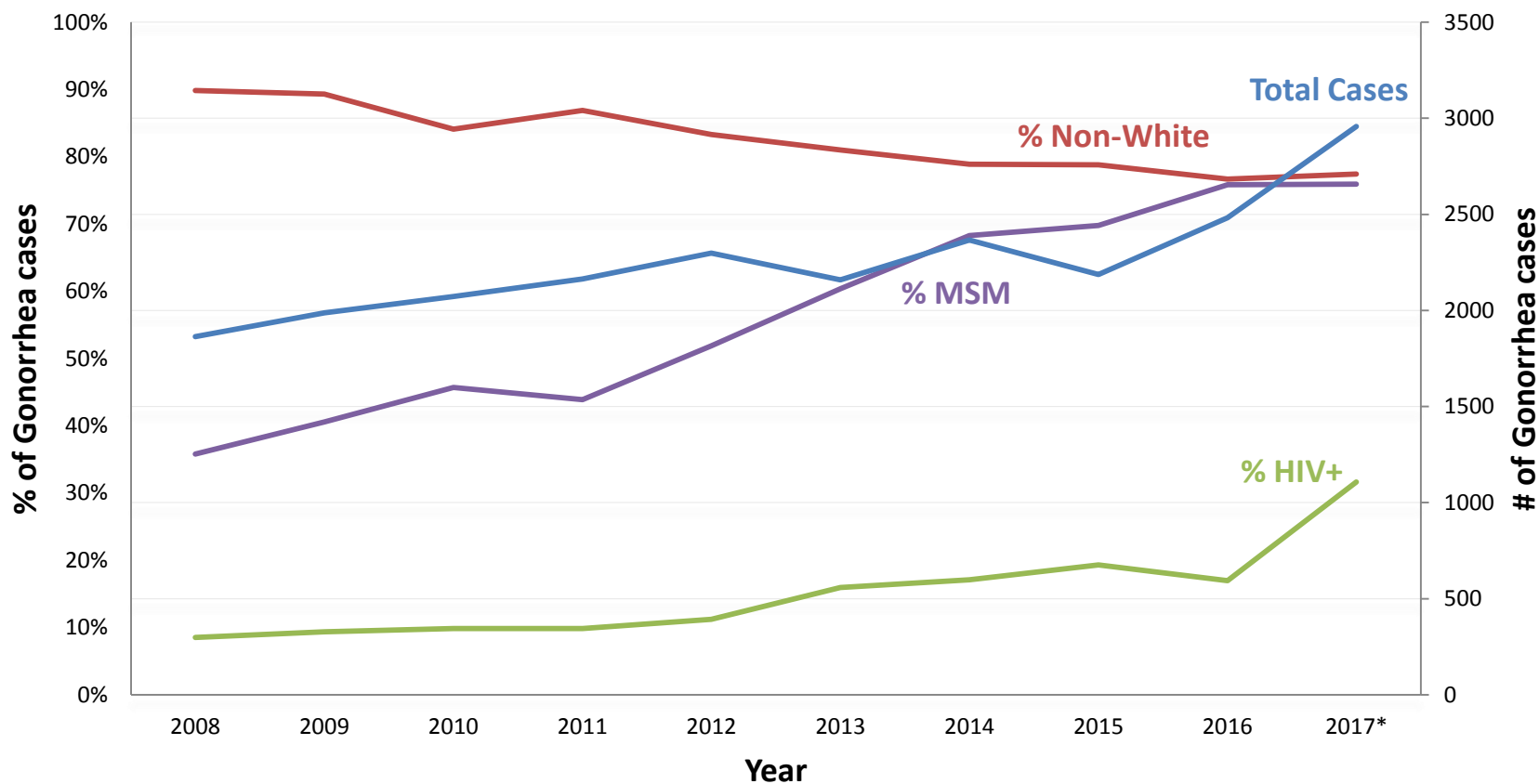


<sup>1</sup> Includes both transgender men and transgender women. Transgender patients represent 0.6% (N=30) of male/trans P&S syphilis cases, 2008-2017

<sup>2</sup> MSM estimates include patients identifying as men; patients identifying as transgender are not categorized as MSM

\*2017 data are annualized using data from 1/1/17-6/30/17

# Gonorrhea diagnosed among male and transgender<sup>1,2</sup> patients with clinician visits to NYC Sexual Health Clinics, 2008-2017\*



<sup>1</sup> Includes both transgender men and transgender women. Transgender patients represent 0.2% (N=39) of male/trans gonorrhea cases, 2008-2017

<sup>2</sup> MSM estimates include patients identifying as men; patients identifying as transgender are not categorized as MSM

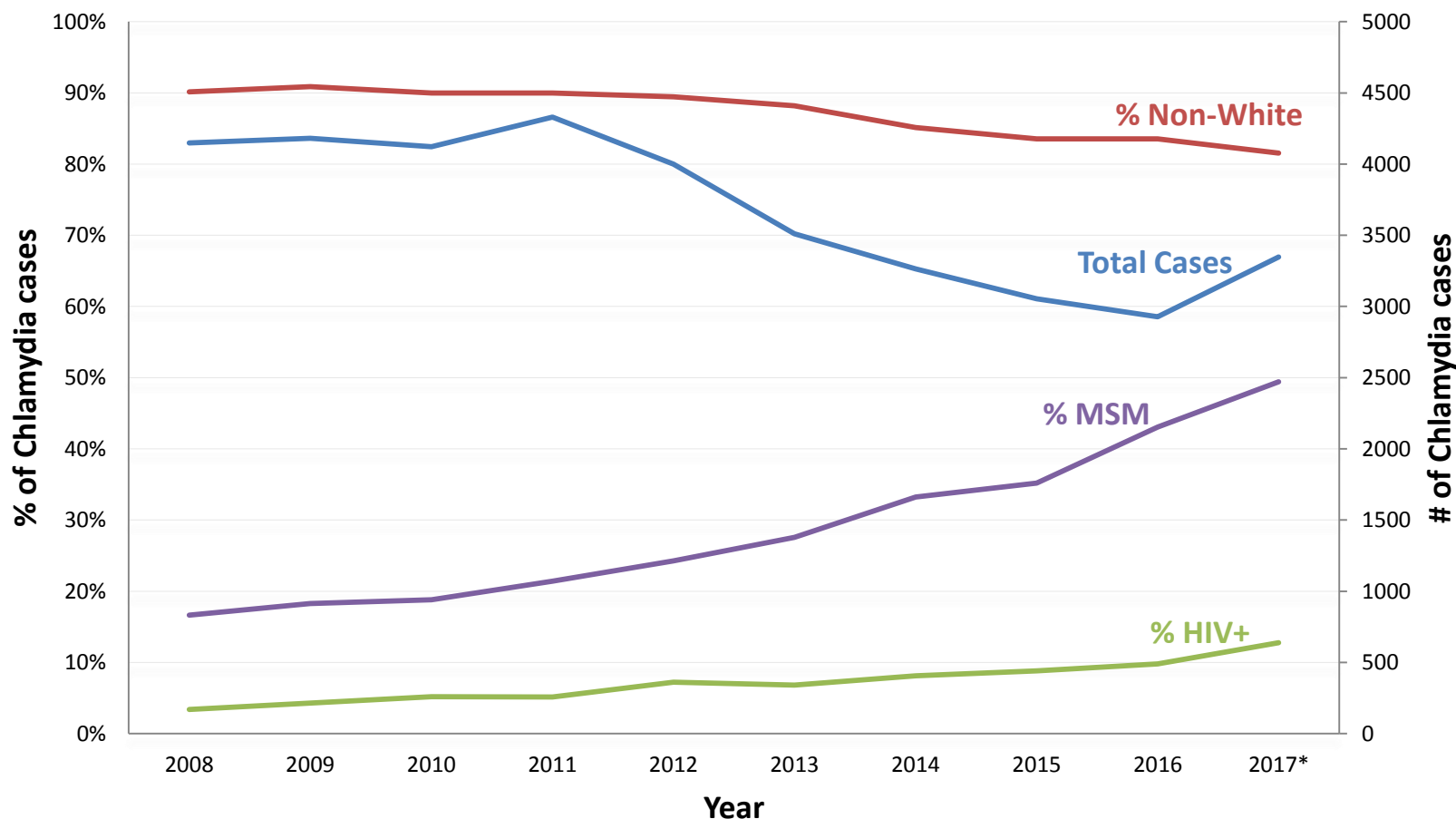
\*2017 data are annualized using data from 1/1/17-6/30/17

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# Chlamydia diagnosed among male and transgender<sup>1,2</sup> patients with clinician visits to NYC Sexual Health Clinics, 2008-2017\*



<sup>1</sup> Includes both transgender men and transgender women. Transgender patients represent 0.1% (N=38) of male/trans chlamydia cases, 2008-2017

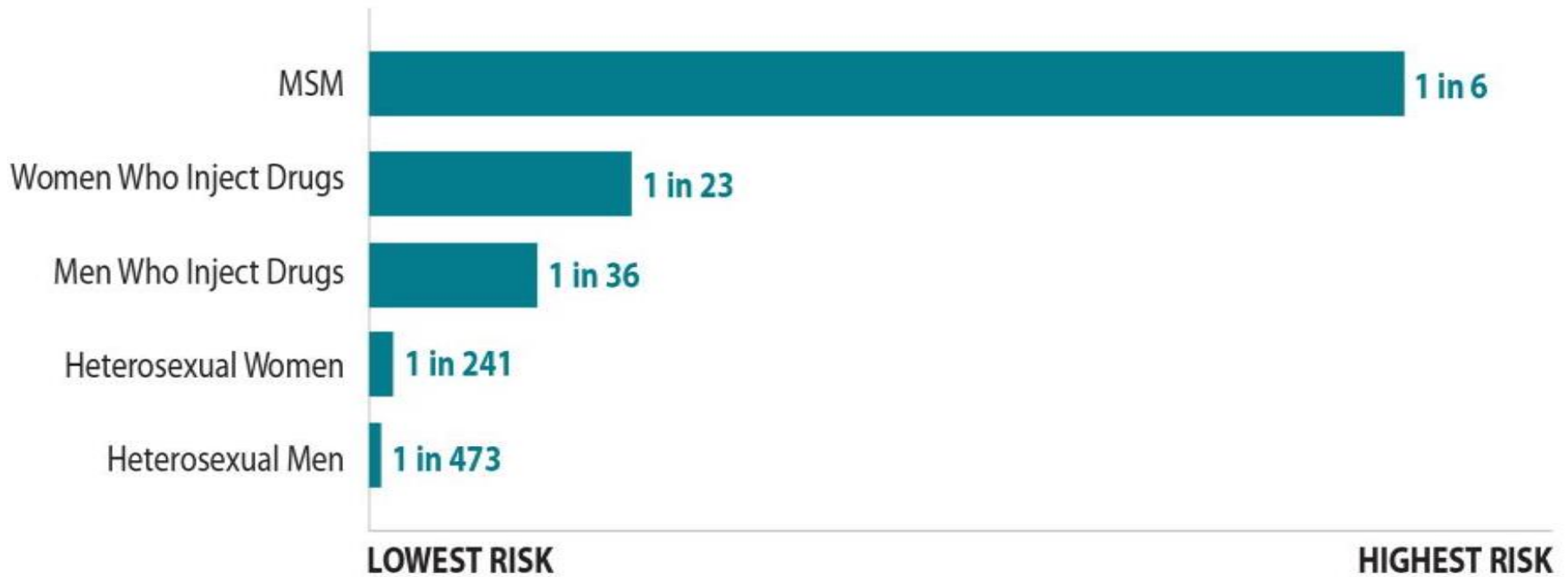
<sup>2</sup> MSM estimates include patients identifying as men; patients identifying as transgender are not categorized as MSM

\*2017 data are annualized using data from 1/1/17-6/30/17

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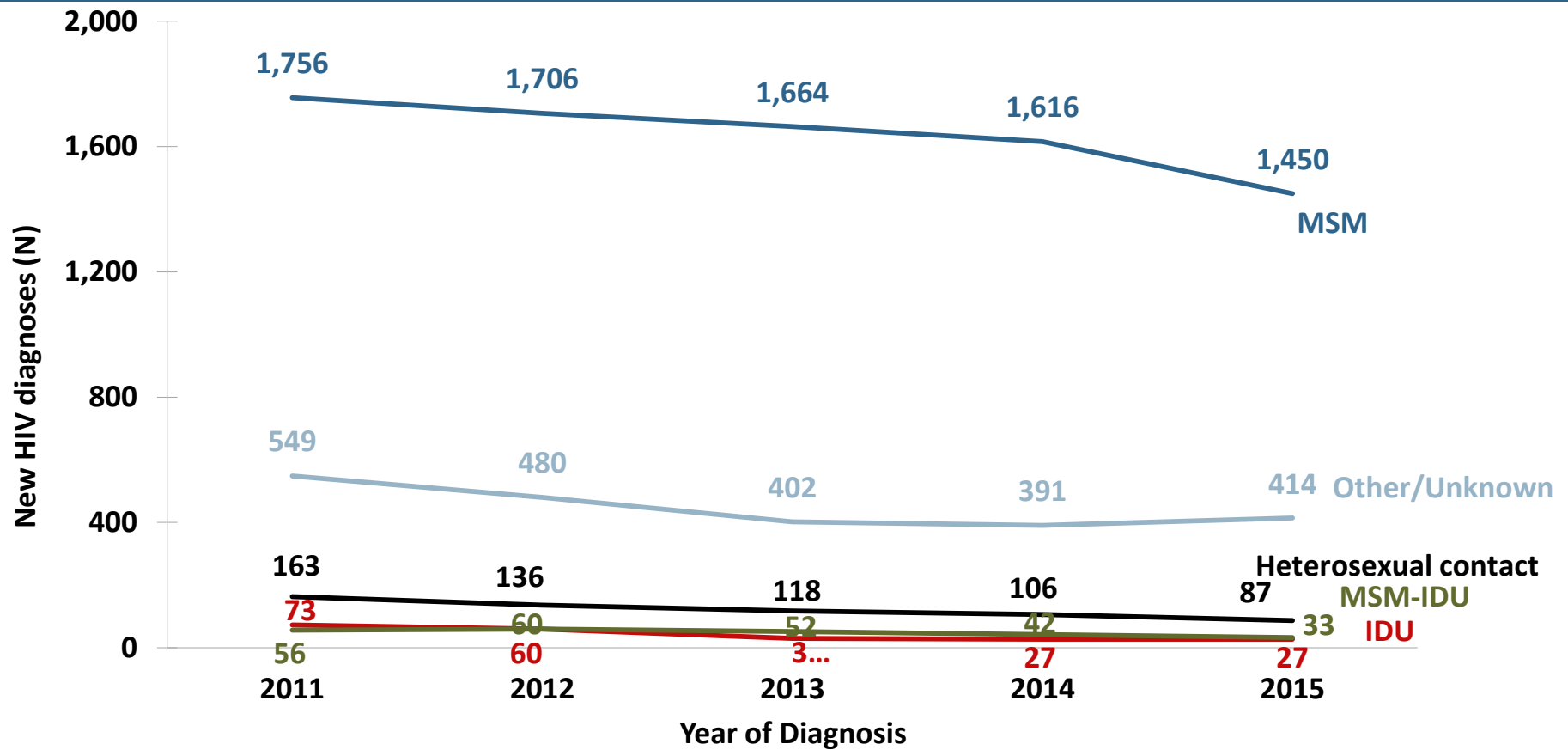


# Lifetime Risk of HIV Diagnosis by Transmission Group, United States



Source: Centers for Disease Control and Prevention

# NUMBER OF NEW HIV DIAGNOSES IN MALES BY TRANSMISSION RISK IN NYC, 2011-2015



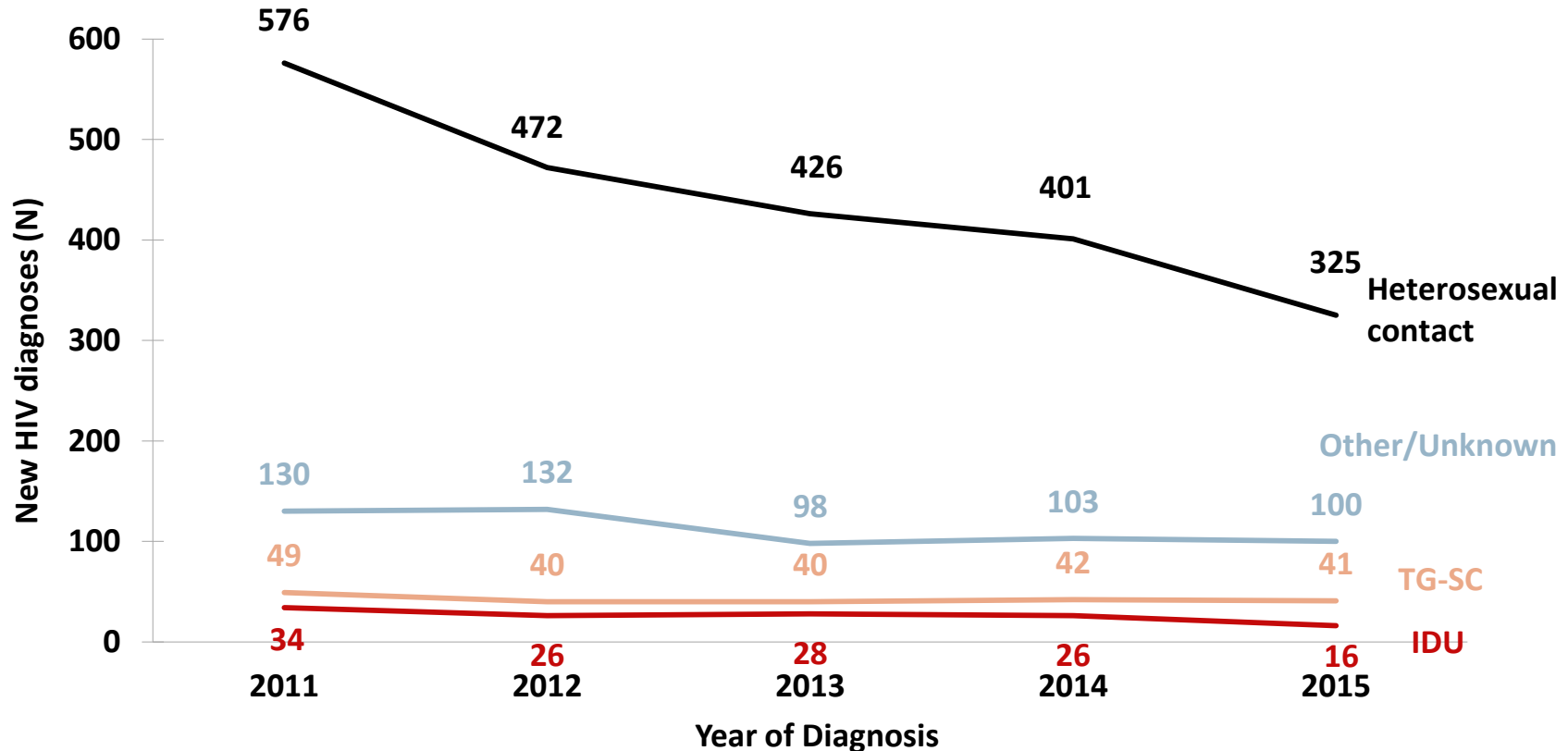
**Overall, the number of new HIV diagnoses decreased among males in all transmission risk groups in NYC between 2011 and 2015.**



Males include transgender men. Other/Unknown includes perinatal exposure, risk factor not reported or not identified, and transgender people with sexual contact.

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2016.

# NUMBER OF NEW HIV DIAGNOSES IN FEMALES BY TRANSMISSION RISK IN NYC, 2011-2015



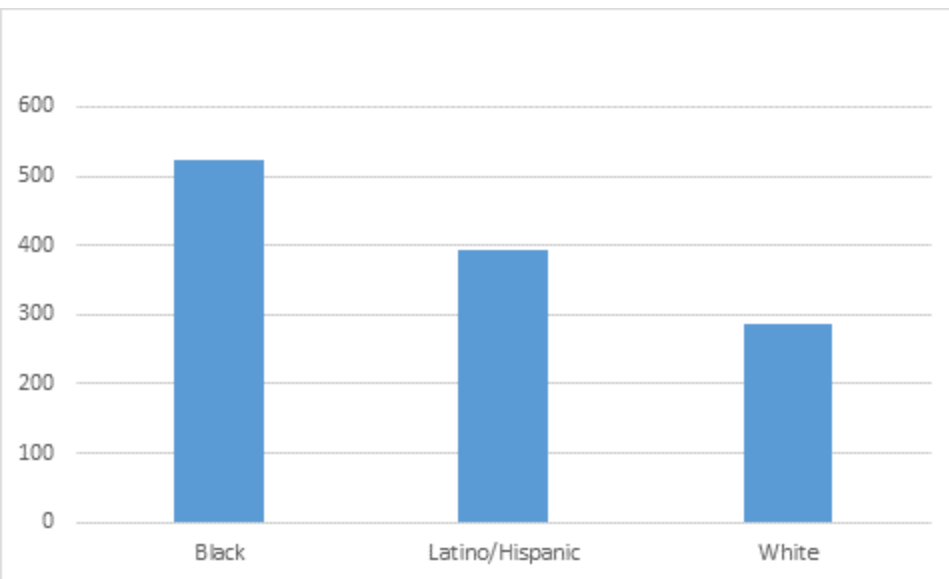
**Overall, the number of new HIV diagnoses decreased among females in all transmission risk groups in NYC between 2011 and 2015.**

Females include transgender women. TG-SC = Transgender people with sexual contact. Other/Unknown includes perinatal exposure and risk factor not reported or not identified. As reported to the New York City Department of Health and Mental Hygiene by June 30, 2016.

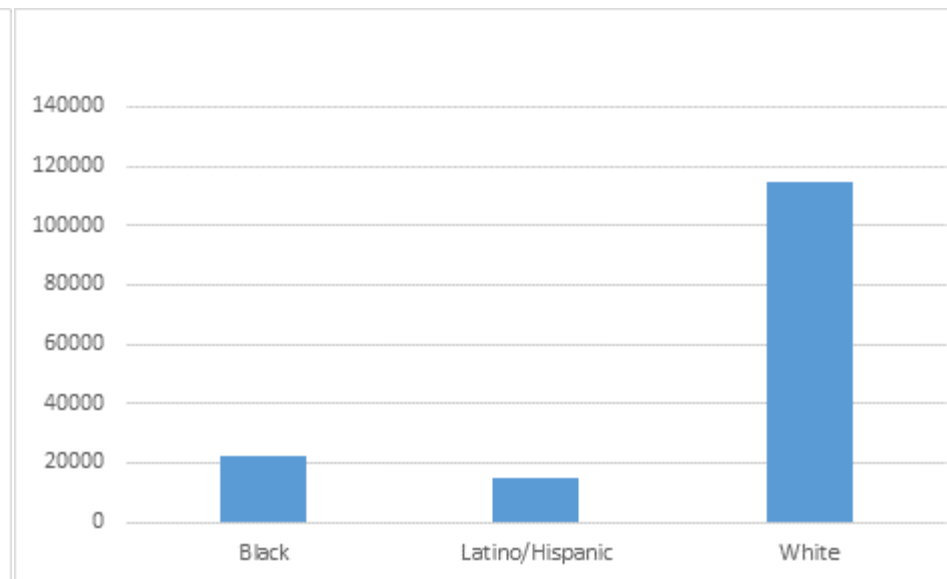
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# New HIV diagnoses among MSM in 2015 vs. prevalence of MSM in NYC in 2015 – by race/ethnicity

New HIV diagnoses among  
MSM – 2015\*



Estimated number of MSM  
in NYC – 2015\*\*



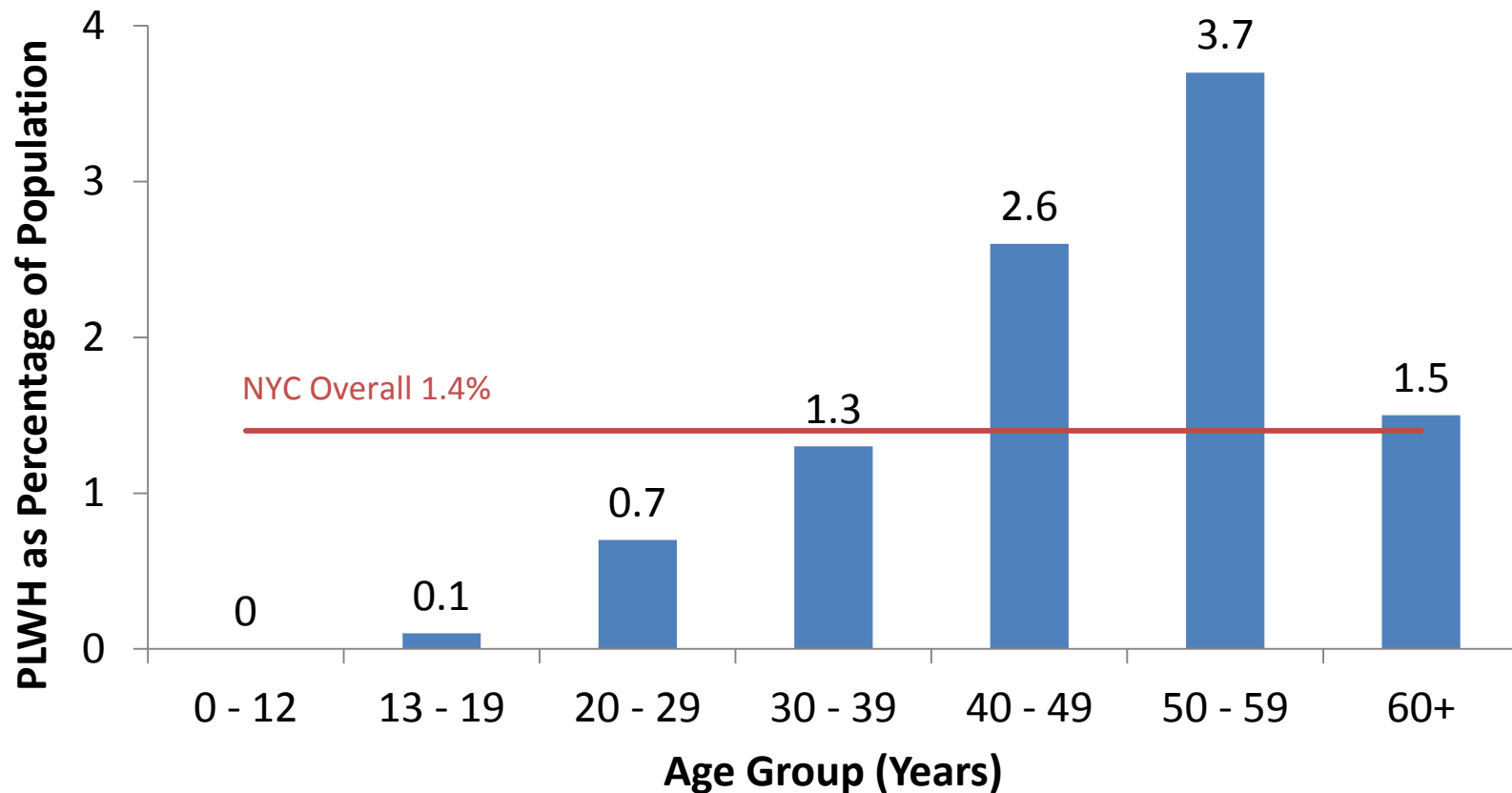
\*Source: NYC HIV Surveillance registry, data as reported  
by June 30, 2016

\*\*Source: Community Health Survey, NYC

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# HIV prevalence by age in New York City, 2015

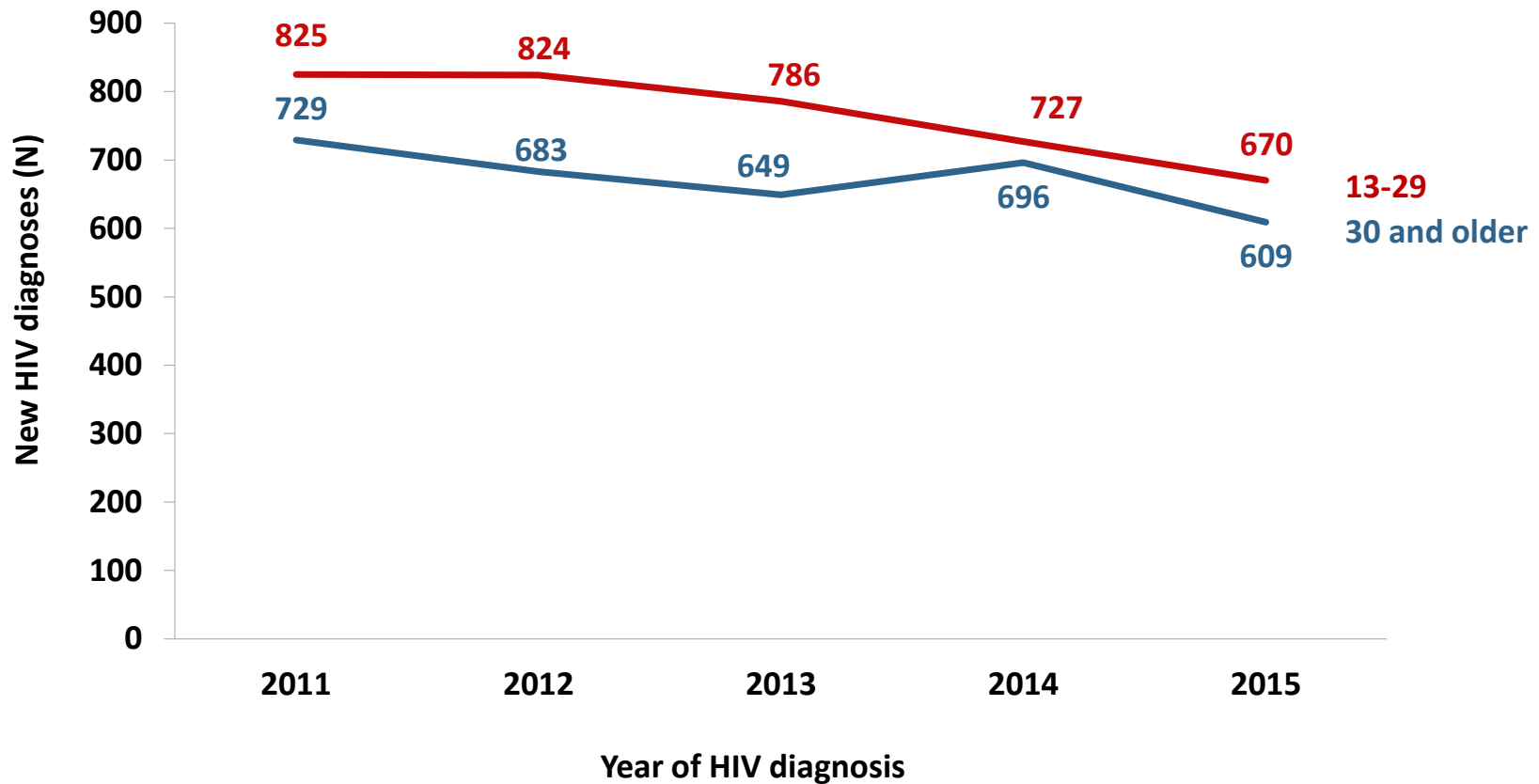


Percentages calculated using the intercensal 2015 NYC population.  
As reported to the NYC Department of Health and Mental Hygiene by June 30, 2016.

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# NUMBER OF NEW HIV (NON-AIDS) DIAGNOSES AMONG MSM\* BY AGE IN NYC, 2011-2015



Starting in 2007, over half of new HIV diagnoses among MSM have occurred in young men ages 13-29. Numbers of new diagnoses decreased in both age groups of MSM between 2011 and 2015.

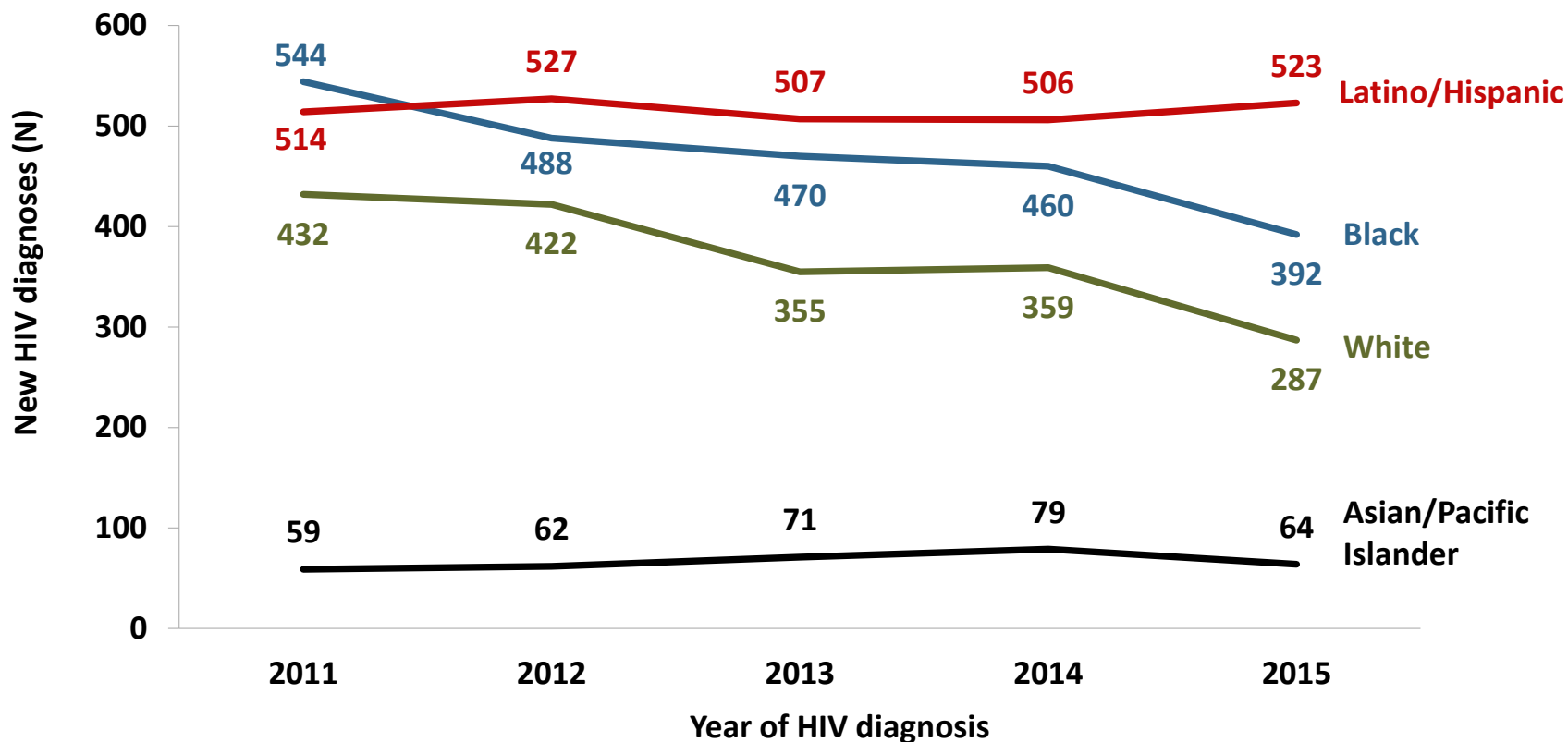
\*Includes MSM-IDU risk category.

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2016

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# NUMBER OF NEW HIV (NON-AIDS) DIAGNOSES AMONG MSM\* BY RACE/ETHNICITY IN NYC, 2011-2015



Since 2011, HIV diagnoses have decreased among Black and White MSM and have been relatively stable among Latino/Hispanic and Asian/Pacific Islander MSM.

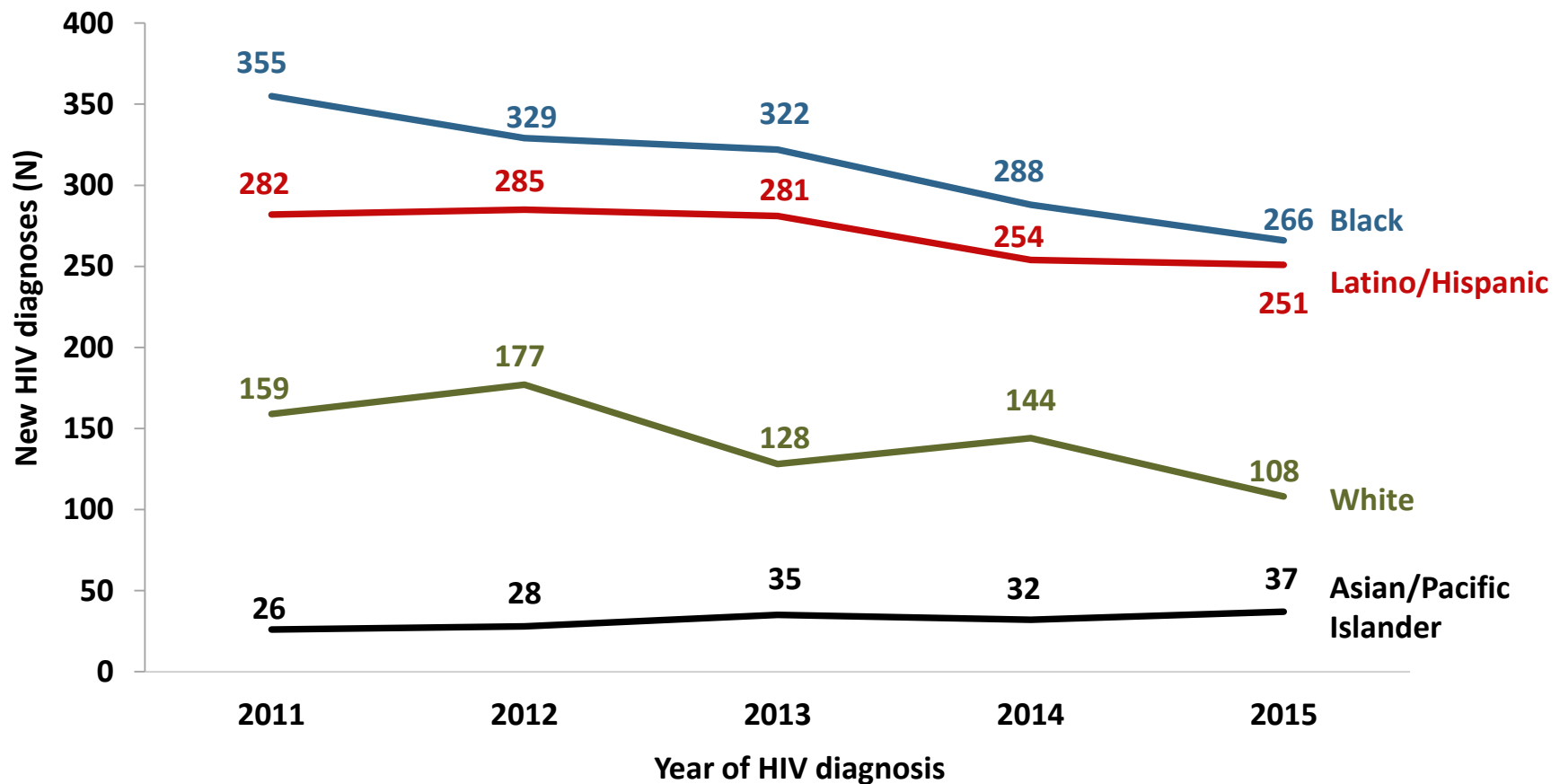
\*Includes MSM-IDU risk category; Native American and multiracial groups not shown due to small numbers. In NYC in 2015, there were N=2 Native American and N=11 multiracial MSM newly diagnosed with HIV (non-AIDS). As reported to the New York City Department of Health and Mental Hygiene by June 30, 2016

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# NUMBER OF NEW HIV (NON-AIDS) DIAGNOSES AMONG YOUNG MSM\* BY RACE/ETHNICITY IN NYC, 2011-2015



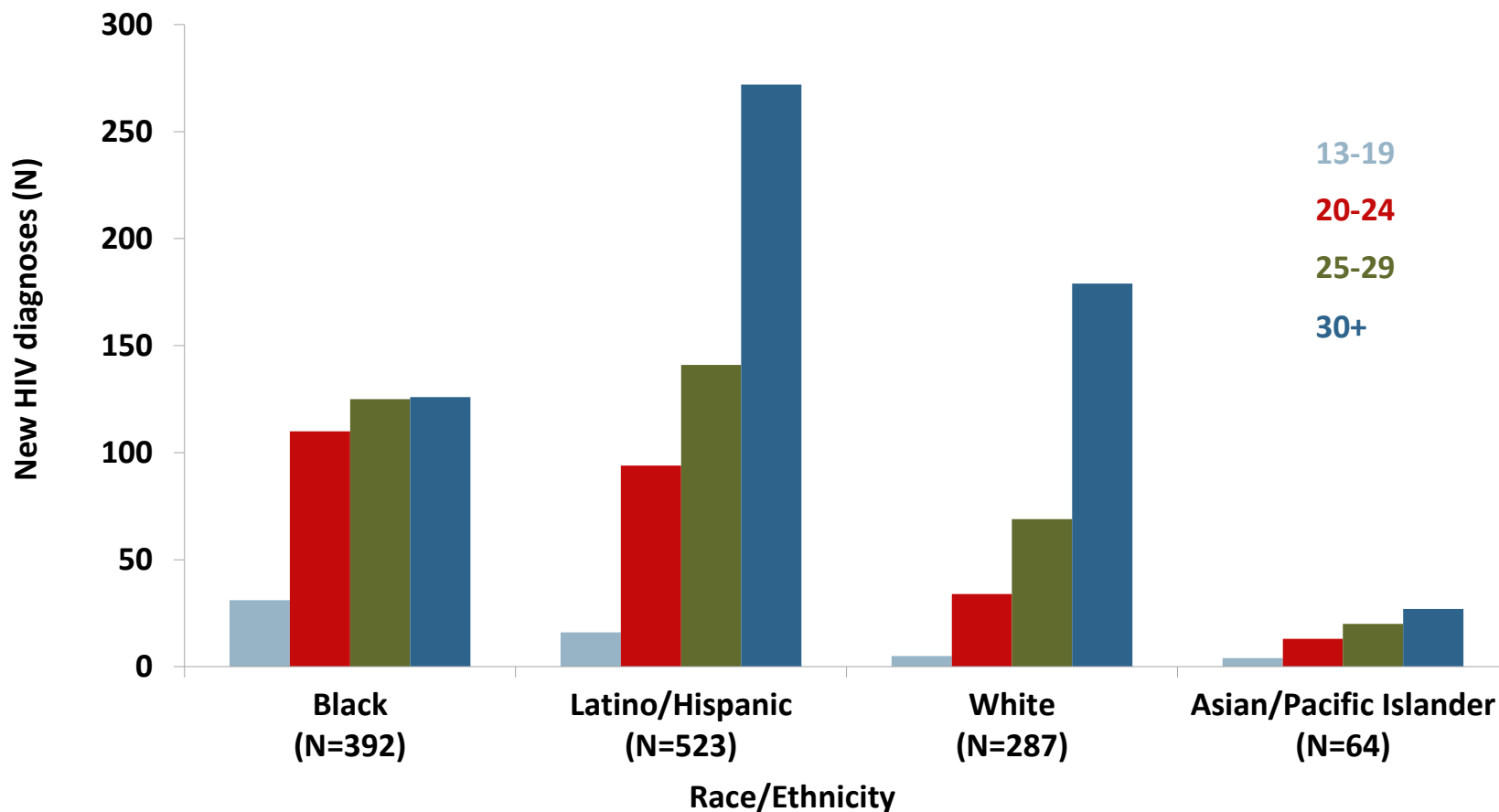
Since 2011, HIV diagnoses have decreased overall among Black, Latino/Hispanic, and White young MSM and remained stable among Asian/Pacific Islander young MSM.

\*Young MSM are those 13-29 years old and include MSM-IDU risk category; Native American and multiracial groups not shown due to small numbers. In NYC in 2015, there were no Native American and N=8 multiracial young MSM newly diagnosed with HIV. As reported to the New York City Department of Health and Mental Hygiene by June 30, 2016

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# NUMBER OF NEW HIV (NON-AIDS) DIAGNOSES AMONG MSM\* BY RACE/ETHNICITY AND AGE IN NYC, 2015



**Young MSM accounted for a larger proportion of new HIV (non-AIDS) diagnoses among MSM of color than among White MSM in NYC in 2015.**

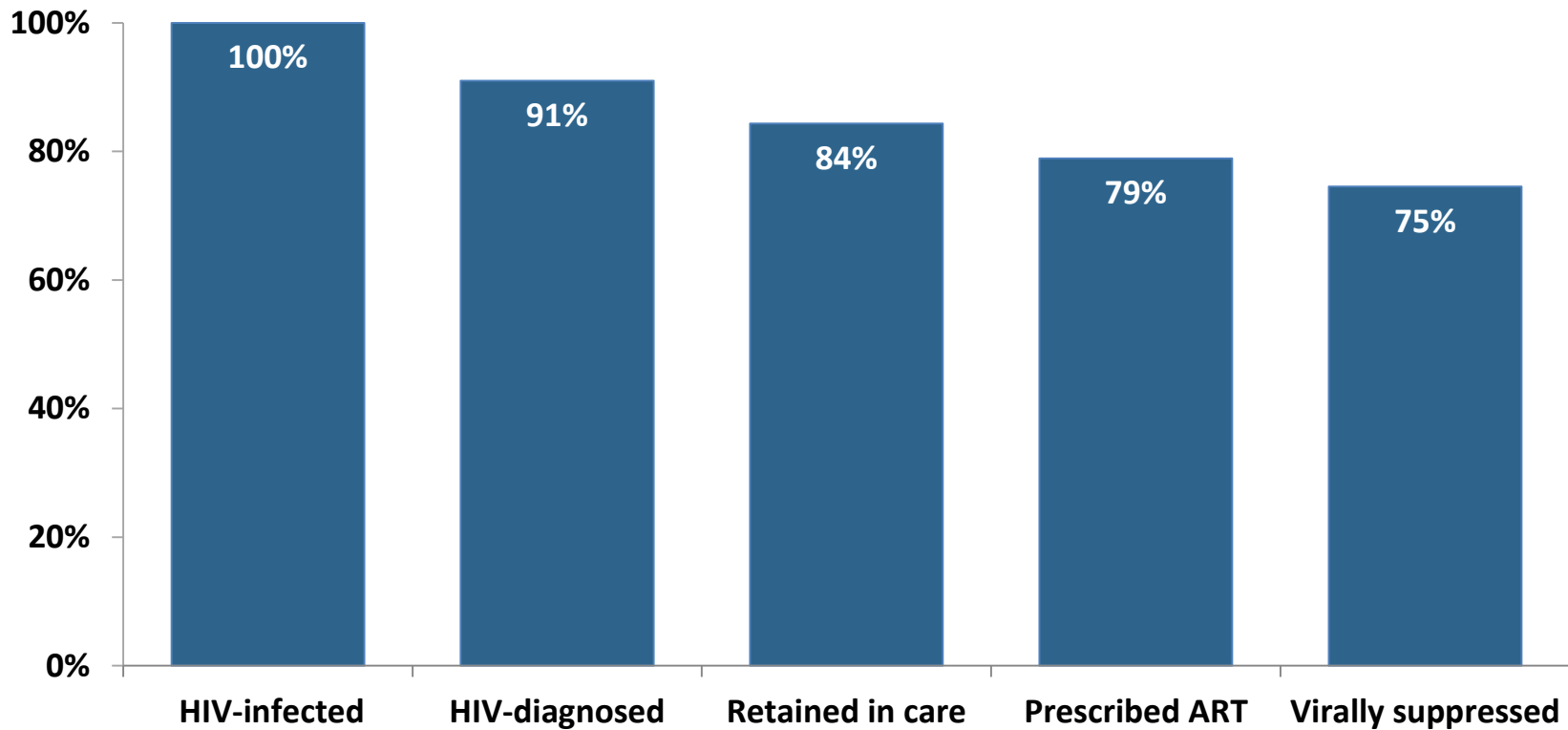
\*Includes MSM-IDU risk category.

Native American and multiracial groups not shown due to small numbers. In NYC in 2015, there were N=2 Native American and N=11 multiracial MSM newly diagnosed with HIV.

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2016



# PROPORTION OF HIV-INFECTED MSM\* IN NYC ENGAGED IN SELECTED STAGES OF THE HIV CARE CONTINUUM, 2015



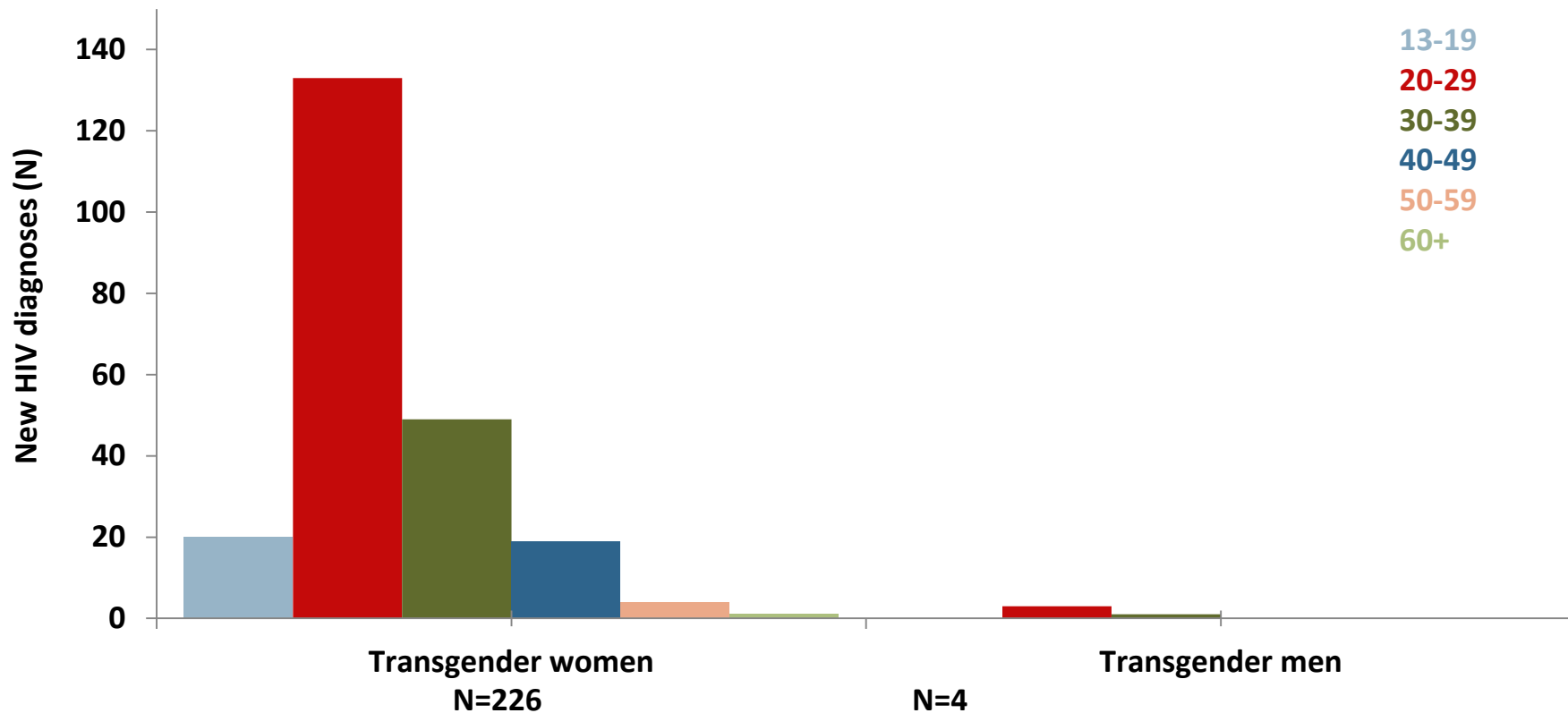
**Of the approximately 38,000 MSM\* infected with HIV and living in NYC in 2015, 75% had a suppressed viral load.**

\*Includes MSM-IDU risk category.  
As reported to the New York City Department of Health and Mental Hygiene by June 30, 2016

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# NEW HIV DIAGNOSES AMONG PEOPLE IDENTIFIED AS TRANSGENDER BY GENDER IDENTITY AND AGE AT DIAGNOSIS IN NYC, 2011-2015



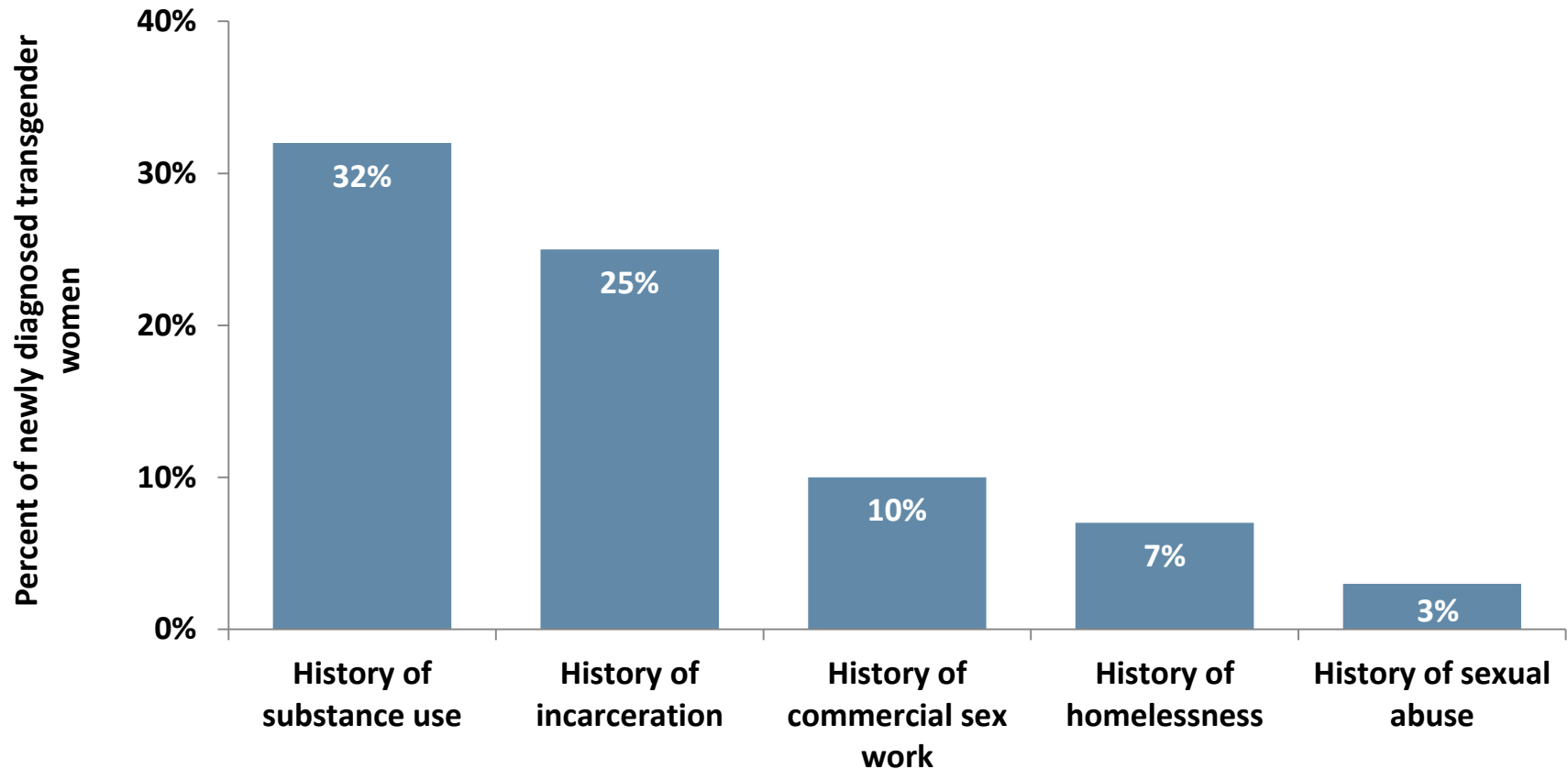
**The majority of newly diagnosed transgender women were in their 20s at diagnosis.  
Newly diagnosed transgender men were in their 20s or 30s.**

# NEW HIV DIAGNOSES AMONG PEOPLE IDENTIFIED AS TRANSGENDER BY GENDER IDENTITY AND RACE/ETHNICITY IN NYC, 2011-2015



**Ninety-two percent of transgender women newly diagnosed with HIV between 2011-2015 were Black or Latina/Hispanic. Newly diagnosed transgender men were Black or Latino/Hispanic.**

# ADDITIONAL CHARACTERISTICS OF TRANSGENDER WOMEN NEWLY DIAGNOSED WITH HIV IN NYC, 2011-2015



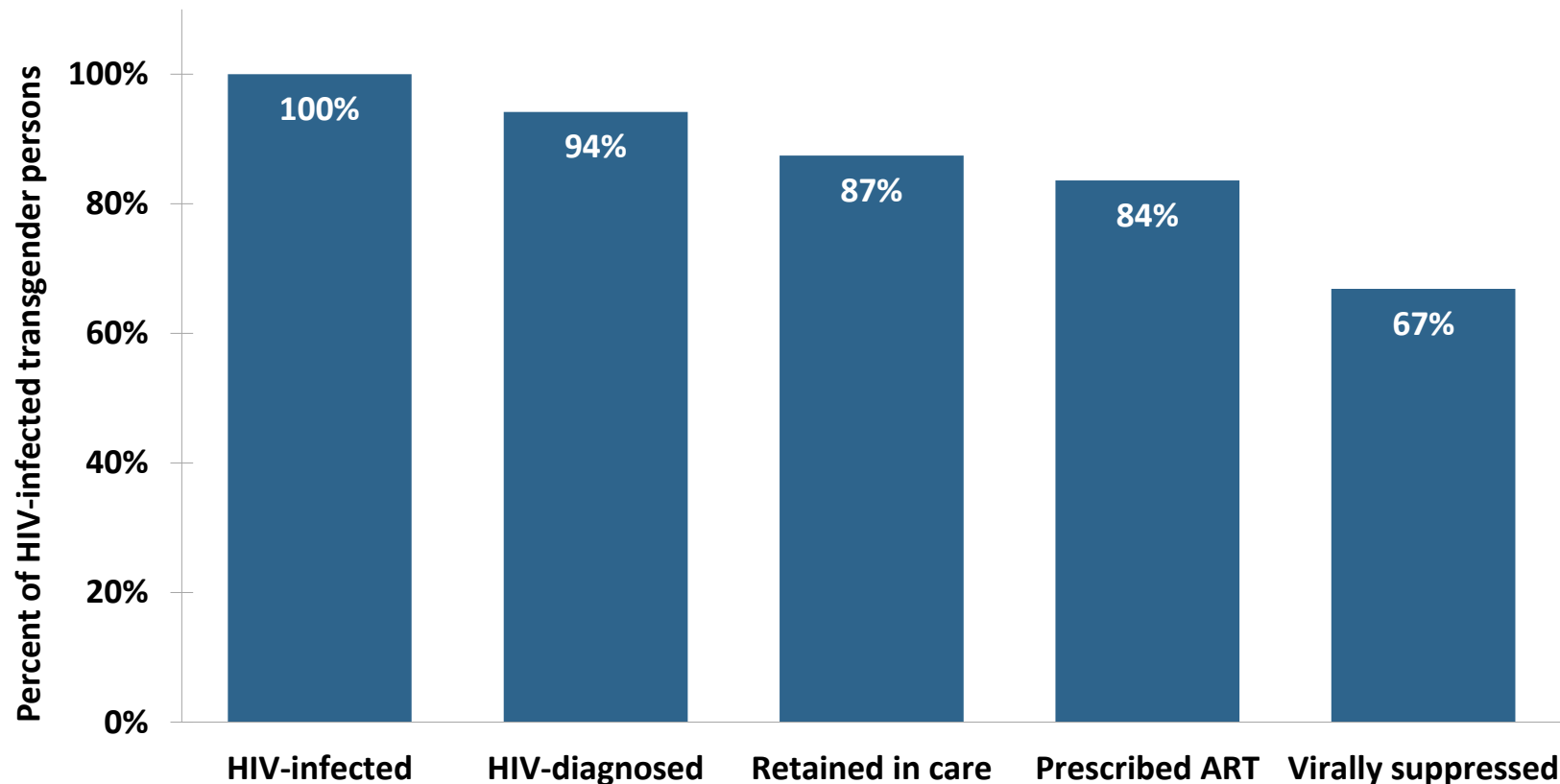
Among the 226 newly diagnosed transgender women in 2011-2015, 49% had a history of at least one of the characteristics presented above\*, compared with 32% of cis-gender people (not shown).

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\*Characteristics documented in medical record. People may have reported more than one characteristic. As reported to the NYC Department of Health and Mental Hygiene by June 30, 2016.

# PROPORTION OF HIV-INFECTED PEOPLE IDENTIFIED AS TRANSGENDER ENGAGED IN SELECTED STAGES OF THE HIV CARE CONTINUUM IN NYC, 2015



**Of the approximately 910 transgender people infected with HIV and living in NYC in 2015, 67% had a suppressed viral load.**

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2016.



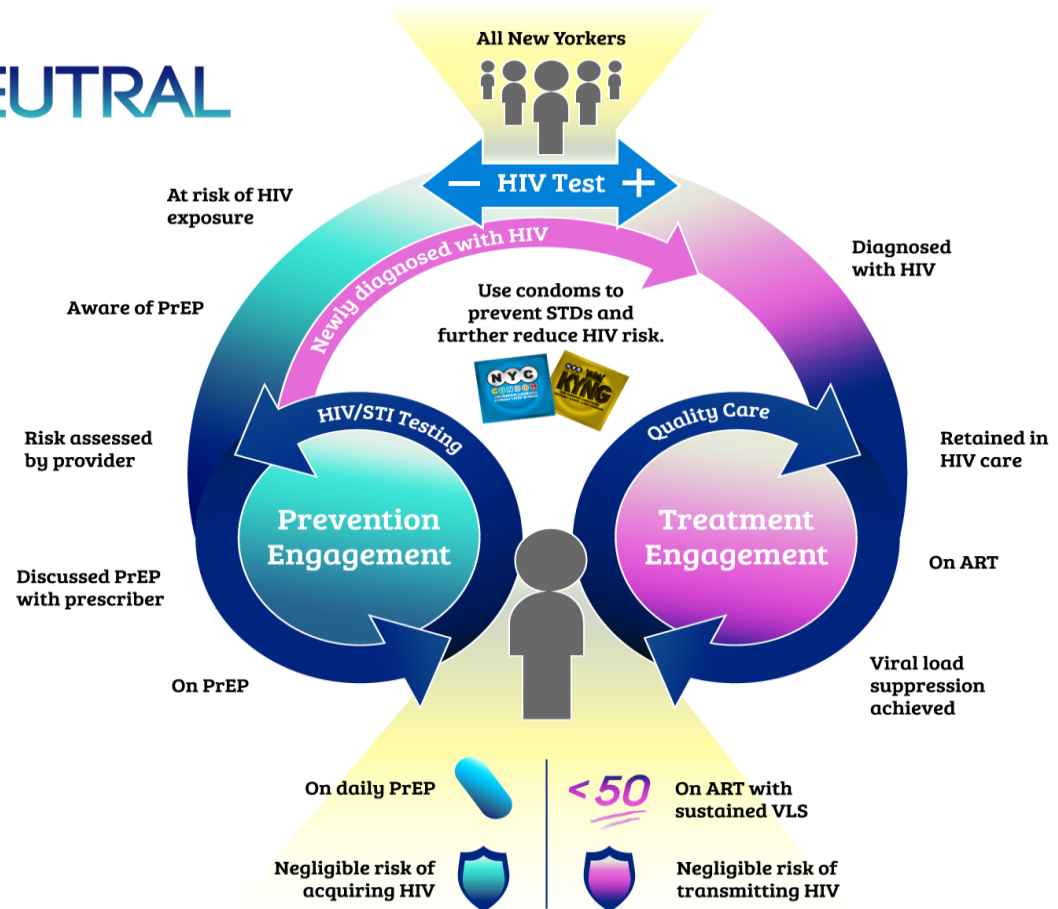
# HIV Screening of MSM by Health Care Providers

- Online survey in 2009 of 4620 HIV negative MSM recruited from social networking site
- 76% previously tested for HIV
- Only 30% reported being offered HIV testing by provider in previous year
- Only 44% disclosed their sexuality to provider—those who disclosed more likely to be offered HIV testing
- Providers need more training to elicit sexual histories from sexual and gender minority patients

Wall et al. *JIA PAC*, Sept/Oct 2010

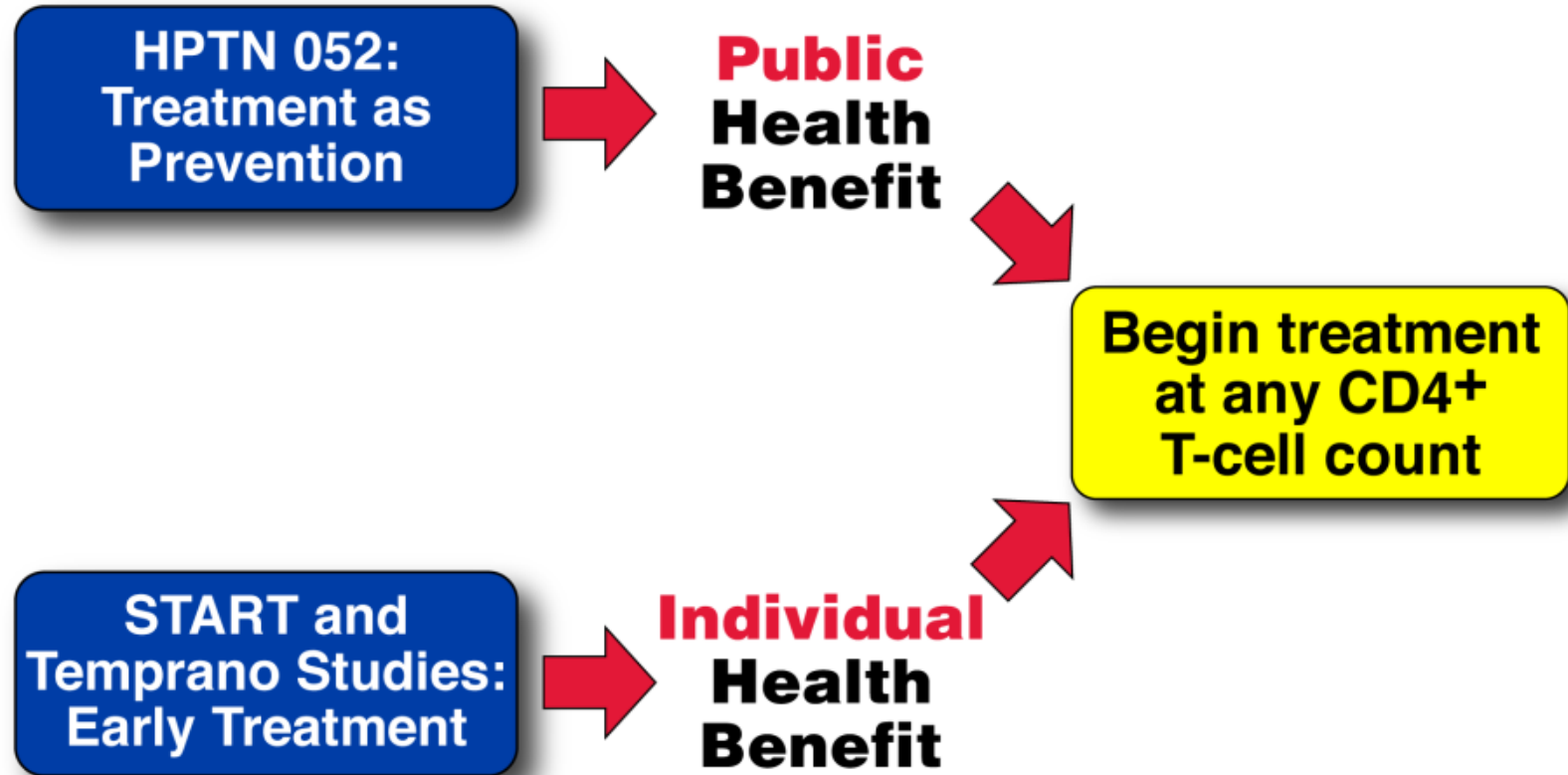


# NEW YORK CITY'S HIV STATUS NEUTRAL PREVENTION & TREATMENT CYCLE



People at risk of HIV exposure **taking daily PrEP** and people with HIV **with sustained viral load suppression** do not acquire or transmit HIV.

# The New Paradigm: Treatment as Prevention



# CDC Guidance on PrEP for HIV Prevention: Candidates

	MSM	Heterosexual Women and Men	Injection Drug Users
Potential indicators of substantial risk of acquiring HIV infection	<ul style="list-style-type: none"> <li>▪ HIV-positive sexual partner</li> <li>▪ Recent bacterial STI</li> <li>▪ High number of sex partners</li> <li>▪ History of inconsistent or no condom use</li> <li>▪ Commercial sex work</li> </ul>	<ul style="list-style-type: none"> <li>▪ HIV-positive sexual partner</li> <li>▪ Recent bacterial STI</li> <li>▪ High number of sex partners</li> <li>▪ History of inconsistent or no condom use</li> <li>▪ Commercial sex work</li> <li>▪ In high-prevalence area or network</li> </ul>	<ul style="list-style-type: none"> <li>▪ HIV-positive injecting partner</li> <li>▪ Sharing injection equipment</li> <li>▪ Recent drug treatment (but currently injecting)</li> </ul>
Clinically eligible	<ul style="list-style-type: none"> <li>▪ Documented negative HIV test result; no signs/symptoms of acute HIV infection</li> <li>▪ Creatinine clearance <math>\geq 60</math> mL/min; no contraindicated medications</li> <li>▪ Documented hepatitis B virus infection and vaccination status</li> </ul>		

# Trans Specific Sexual Health Issues

## Intrapersonal

- Internalized transphobia
- Low self-esteem
- Depression and self-harm
- Gender identity validation through sex
- Multiple injection risks (IDU, ISU, IHU)

## Interpersonal

- Societal Transphobia
- Family rejection
- Peer harassment
- High risk sex partners
- Sex work
- Conflation with MSM
- Lack of support for families

## Institutional

- Transphobia
- Health care
- Educational Settings
- Employment discrimination
- Housing discrimination
- Prisons and jails
- Religion
- Health Departments

# HIV/STI Risk Behavior in WSW

- Large studies (Sydney N=14,899; Seattle N=18,585) show increases in classic HIV risk factors in STD clinic attendees in bisexual women
- Risks include
  - ⇒ more recent partners
  - ⇒ sex with partners at high risk for HIV
  - ⇒ injection drug + crack cocaine use
  - ⇒ exchange of sex for drugs or money
- Women reporting sex only w/ women: more commonly, sex w/ bisexual man or HIV+ partner
- WTW transmission of BV, HSV, not HIV  
? Role of shared sex toys

Fethers STI 2000; Marrazzo Intl J AIDS STD 2001; Chapman AJPH 1999



# Substance Use and Other Mental Health Issues



# Mental Health Issues

- 40% of MSM become depressed, 2X the lifetime rate of heterosexuals
- Predictors of major depression are: not having a partner, experiencing anti-gay threats or violence, non-identification as gay
- Panic disorder, social phobia, generalized anxiety disorder are more common among MSM (20% lifetime incidence)
- Culturally-tailored treatment may involve groups that enhance community identification



(Sandfort, Arch Gen Psych, 2001; Gilman, AJPH, 2001; Lewis, Health Place, 2010; Safren, Health Psychology, 2012)

# Substance Use and MSM

- Substance use during sex is often associated with HIV and STIs in MSM in many countries
- Common drug combinations associated with risk include: meth, cocaine, poppers
- May ↑ libido, sensation, sense of invulnerability, but impairs negotiation, associated with ↑ risky networks
- ↓ pain threshold → traumatic sex
- For HIV+ pts, SU may decrease medication adherence
- Culturally-tailored programs that include groups and/or support MSM identity, have been more successful in decreasing cigarette and crystal methamphetamine use than conventional interventions

(Colfax, Lancet, 2010; van Griensven, J Int AIDS Soc, 2010; Johnston, Int J Drug Pol, 2010; Bautista, STI, 2004; Parry, Drug Alcohol Dep, 2008; Koblin, AIDS, 2006; Cochran, Sub Use Misuse, 2007; Shoptaw, J Sub Abuse Treat, 2008; Mausbach, Drug Alcohol Depend, 2007; Mansergh, PLOS Med, 2010)





# Disparities in Cancer



# SGM Disparities in Cancer Rates\*

Cancer Site	Disparities in Cancer Rates Observed in LGBT Populations
<b>Cervix</b>	Higher prevalence among bisexual (41.2%) and lesbian (16.5%) than heterosexual (14.0%) women [California Health Interview Survey; results may not be generalizable]
<b>Anus</b>	Higher incidence among HIV+ MSM (45.9/100,000 PY) and HIV-MSM (5.1/100,000 PY) than men in the general population (1.5/100,000 PY)[meta-analysis of 9 published studies]
<b>Lung</b>	Higher incidence in geographic areas with a greater density of gay men; ↑ incidence among HIV-infected persons
<b>Breast, Uterus, Ovary, Prostate, Colon/Rectum</b>	Unknown (lack of SO/GI data in national databases/registries)

CA Cancer J Clin 2015; 65: 384-400.

\*No high quality evidence on mortality



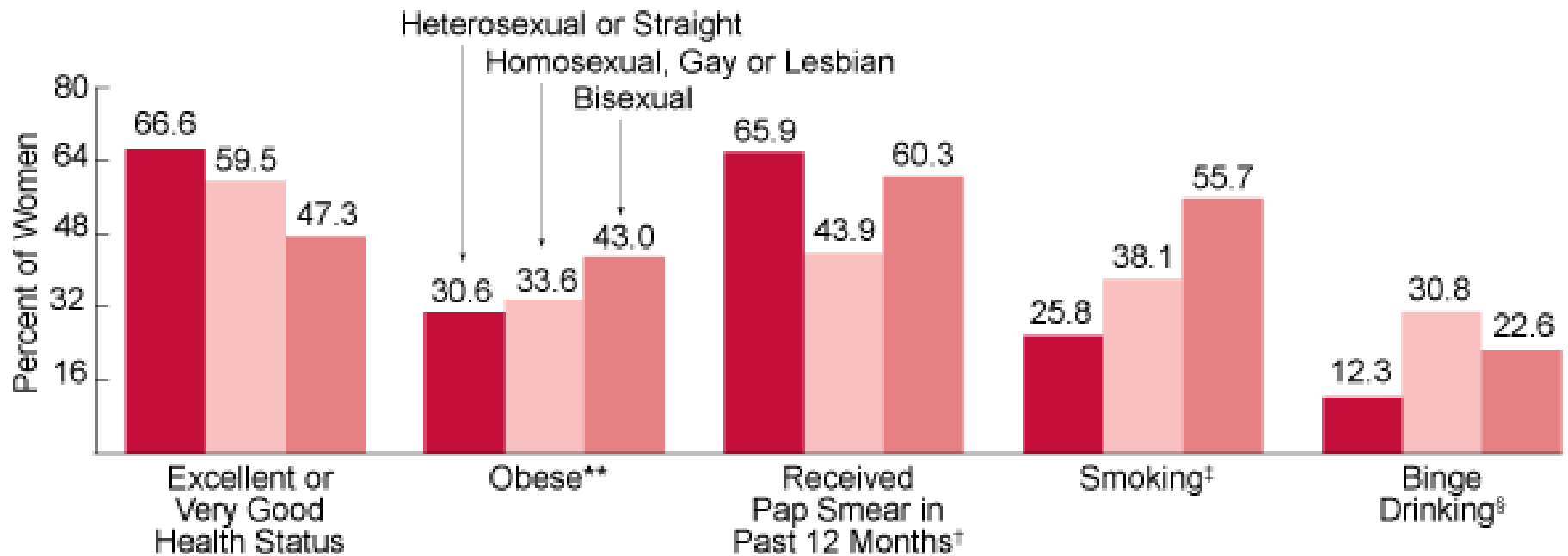
# SGM Disparities in Cancer Screening

Cancer Site	Disparities in Rates of Cancer Screening in LGBT Populations
<b>Breast</b>	Studies of mammography utilization among SMW → inconsistent findings
<b>Cervix</b>	↓ screening (lesbians, trans men); ↑ unsat. cytology (trans men)
<b>Uterus, Ovary</b>	N/A (no evidence-based screening)
<b>Prostate</b>	↓ PSA screening among Black MSM and low-income HIV-infected men
<b>Anus</b>	N/A (no general population anal cancer screening program)
<b>Colon/Rectum</b>	Unknown (limited studies among SM populations)
<b>Lung</b>	Unknown (no studies among SGM populations)

CA Cancer J Clin 2015; 65: 384-400.



# Selected Health Indicators Among Women Aged 18–44 Years, by Sexual Identity, 2006–2010\*



\*Estimates are age-adjusted. \*\*Based on Body Mass Index (BMI), a number calculated from a person's weight and height. Obese is defined as a BMI of 30.0 or higher. †Calculated for females aged 20–44 years. ‡Smoked at least one cigarette per day on average in the past year. §Defined as consuming 5 or more drinks within a couple of hours at least once a month on average in the past year.

Source: Chandra A, Copen CE, Stephen EH. Infertility and impaired fecundity in the United States, 1982–2010: Data from the National Survey of Family Growth. National health statistics reports; no 67. Hyattsville, MD: National Center for Health Statistics. 2013.

# General Population Screening Recommendations

Cancer Site	Evidence-Based Cancer Screening and Prevention Recommendations
Breast	Mammography (natal females with breast tissue; dueling specifics); clinical breast exam no longer recommended
Cervical	HPV/Pap testing (natal females with a cervix; various guidelines now concordant); HPV vaccination (all natal females to age 26)
Uterus	No effective screening; counsel patients to report abnormal bleeding
Ovary	No effective screening
Prostate	Shared decision-making (all natal males)
Anus	No general population screening; consider anal Pap testing for high-risk patients (MSM with HIV); HPV vaccination (all groups to age 26)
Colon/Rectum	Variety of options starting at age 50 (average risk)
Lung	Low-dose CT in adults aged 55-80 years who have a 30 PY smoking history and currently smoke or have quit within the past 15 years

## Would You Recommend...

- Breast cancer screening for a [trans man after nipple-sparing 'top' surgery] [trans woman on extended estrogen treatment]?
- Cervical cancer screening for a trans woman after 'bottom' surgery with creation of a neocervix?
- Prophylactic hysterectomy/oophorectomy for a trans man on extended testosterone treatment?
- Prostate cancer screening for a trans woman on extended estrogen treatment?

# If SGM-Specific Evidence is Lacking...

- Consult consensus guidelines that have been established for transgender care:
  - UCSF Center of Excellence for Transgender Health: [transhealth.ucsf.edu](https://transhealth.ucsf.edu)
  - Endocrine Society: [endocrine.org](https://endocrine.org)
- Engage in a shared decision-making process
- Support SGM-inclusive data collection and participation in clinical trials

# UCSF Guidance: Trans Men

- *Breast cancer:*
  - Annual chest wall/axillary exam
  - Mammography as for natal females (not needed after chest reconstruction, but consider if only a reduction was performed)
- *Uterine cancer:*
  - Evaluate vaginal bleeding in the absence of a mitigating factor (e.g., missed T doses, excess T dose leading to increased E levels) as for post-menopausal natal females
  - Consider hysterectomy if fertility not an issue, >40 years, and health will not be adversely affected by surgery



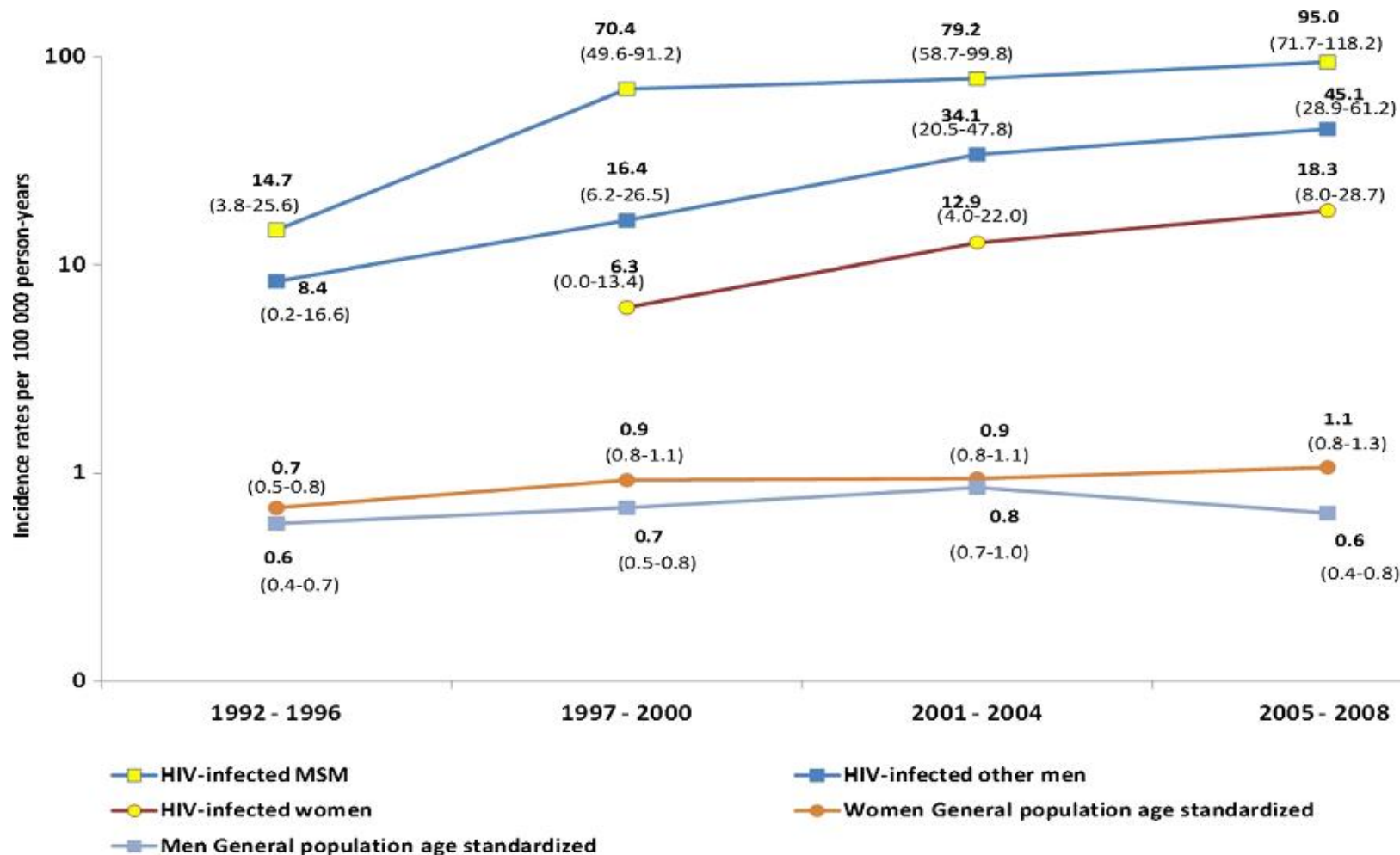
# UCSF Guidance: Trans Women

- *Breast cancer*: screening mammography if >age 50 with additional risk factors (e.g., estrogen and progestin use > 5 years, positive family history, BMI > 35)
- *Prostate cancer*: Limit PSA screening to high-risk patients (PSA is falsely low in androgen-deficient setting). Use DRE to evaluate the prostate in all trans women
- Pap tests in neovaginas are not indicated; the neovagina is typically lined with keratinized epithelium that cannot be evaluated with a Pap test

# Anal HPV Infection

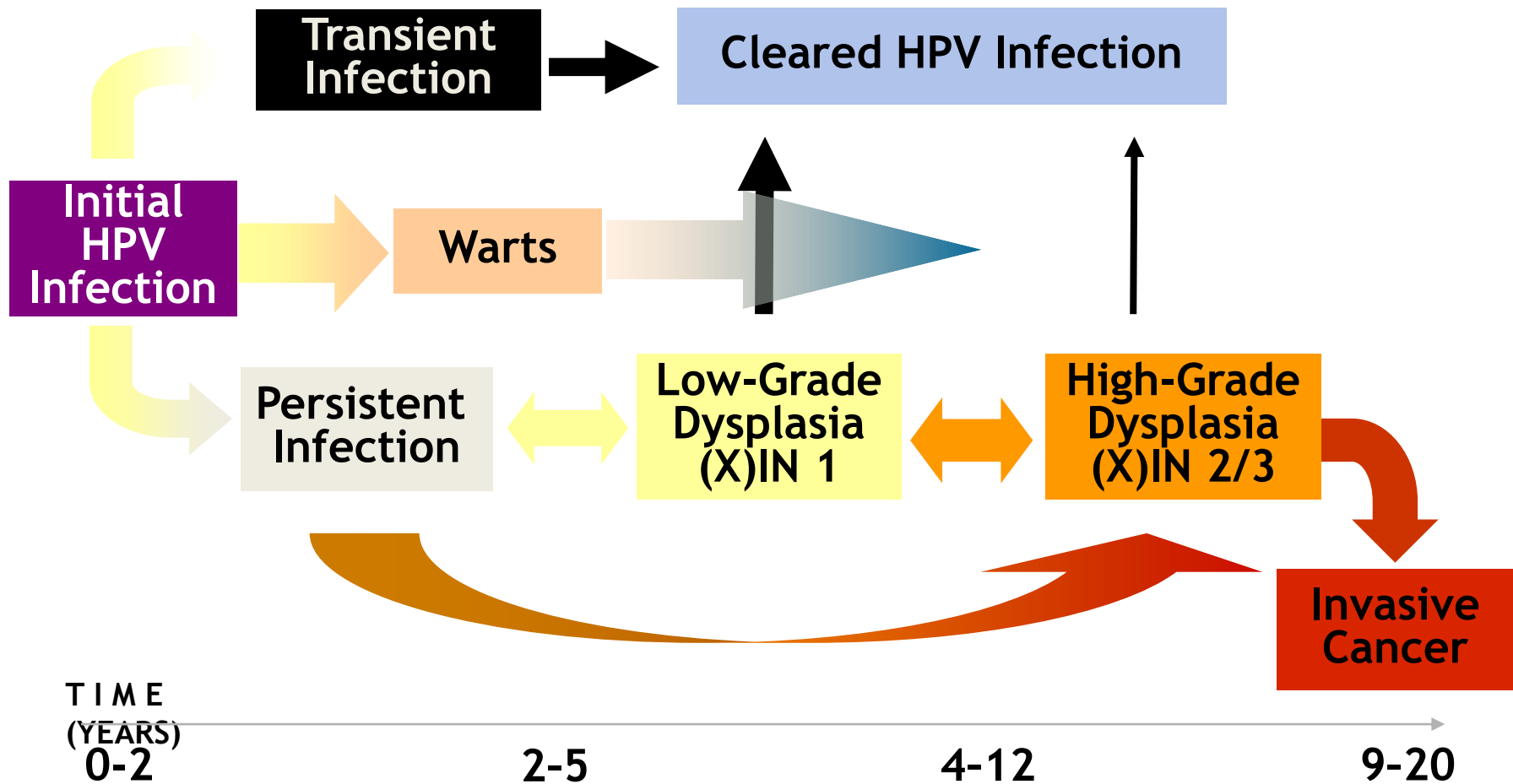
- Cross sectional studies of any HPV detected in anal canal:
  - HIV positive MSM 60-90+%
  - HIV positive women 75%
  - HIV negative MSM 40-60%
  - HIV negative women 40%
- Factors:
  - Age
  - CD4 count

# Anal Cancer Incidence, by group



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it  
all

# Natural History of HPV Infection



**HIV INFECTION COMPRESSES THE NATURAL HISTORY OF HPV INFECTION**

# Anal Pap Recommendations

- **Suggested Populations:**

- HIV-positive individuals
- HIV-negative MSM, [trans women]
- Women [trans men] with high grade cervical/vulvar lesions/cancer
- Individuals with perianal condyloma
- Solid organ transplant recipients

- **Suggested Schedule:**

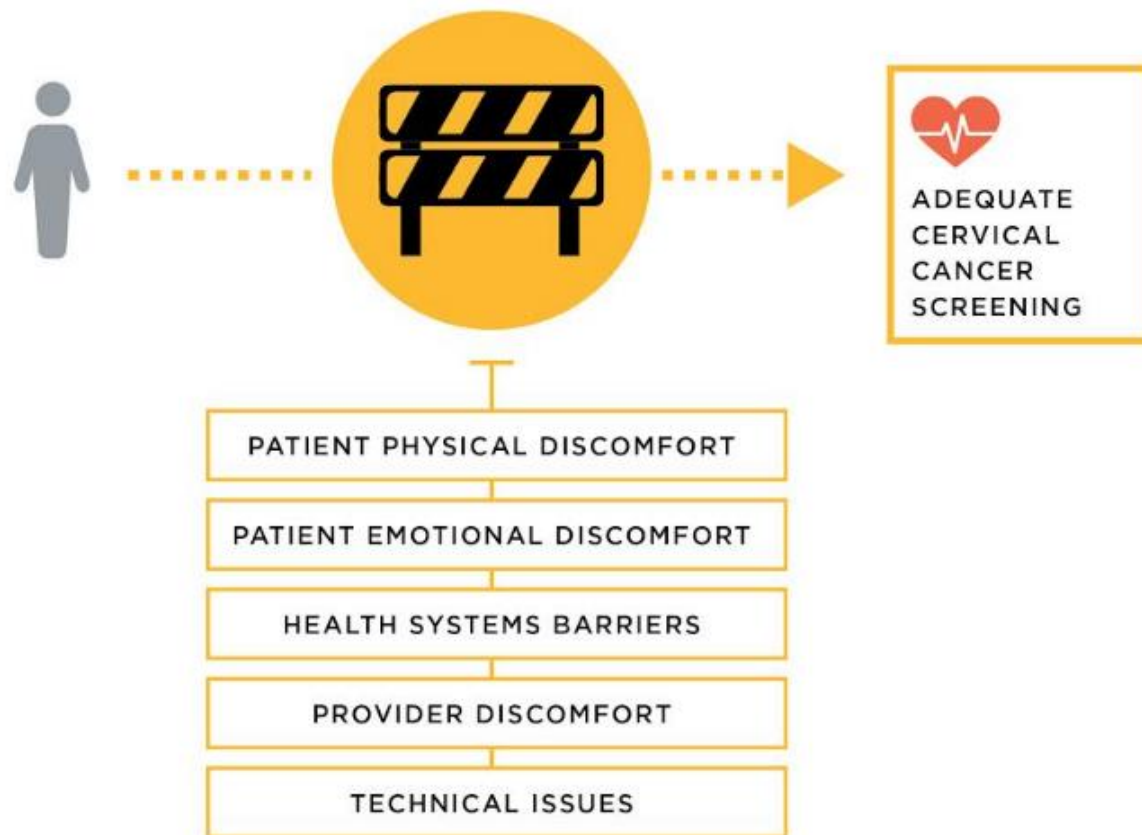
- 30 y.o. and annually if immunosuppressed (HIV)
- 40 y.o. and every 2-3 years if immunocompetent



# Addressing Barriers



# Barriers to Screening and Prevention



# Principles of Trauma-Informed Care (SAMHSA, 2014)



<http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>



# Paradigm Shift

FROM

*What's wrong  
with you?*

TO

*What  
happened to  
you?*

# Carefully Consider Exams/Procedures

- Potential to facilitate diagnosis/healing
- Potential for harm, especially when patients...
  - Have a h/o physical, sexual, emotional, institutional, or healthcare-related traumas
  - Perceive the exam as incongruent with gender identity (e.g., trans woman receiving a prostate exam)
- In the worst case scenario, may...
  - Trigger acute reactions (e.g., dissociation, panic)
  - Lead to future avoidance of care

# Avoid Re-traumatization

- Screen for and acknowledge trauma history / validate coping strategies
- Engage in shared decision-making, especially in the face of uncertain evidence/conflicting guidelines
- Consider alternatives to intrusive exams / procedures (e.g., self-swabs for STIs, FOBT for colon cancer screening)
- Avoid coercive practices (e.g., do not require a Pap test before prescribing hormone therapy)

# Avoid Re-traumatization *(cont.)*

- Explain exam procedures to the extent preferred, using patient's preferred terminology
- Discuss modifications to the exam that can be used to promote emotional and physical comfort
- Ensure that the patient maintains locus of control at all times
- Respond appropriately if the exam triggers an acute stress reaction

## Gender-Neutral Language (Pelvic Exams\*)

Gendered	Less Gendered	Least Gendered
Vulva		External pelvic area, outer parts
Labia		Outer folds
Vagina		Genital opening, frontal pelvic opening, internal canal
Uterus, ovaries	Reproductive organs	Internal organs, internal parts
Breasts		Chest
Pap smear	Pap test	Cancer screening
	Cervical cancer	Cancer, HPV
Bra, panties		Underwear
Pads, tampons		Absorbent product
Period, menstruation		Bleeding

*\*Language may be adapted to male external genital, anorectal, prostate exams  
J Gen Intern Med 2015; 30: 1857-64.*



# Modifications to the Exam

Exam Element or Technique	Modification Options
Chaperone	Patient's choice of support person
Positioning for exam	Feet on table rather than 'footrests'
Speculum selection	Pedersen long narrow or pediatric speculum
Lubricant use	<ul style="list-style-type: none"><li>• Non-carbomer-containing water-based</li><li>• Consider use of topical lidocaine</li></ul>
Speculum insertion	Self-insertion
Cervical sampling	Trans male with prior unsat cytology: pretreat with 2 weeks of vaginal estrogen

J Gen Intern Med 2015; 30: 1857-64.



# Advocacy

- The ACA prohibits group health plans from limiting coverage of sex-specific preventive services based on a patient's SAAB, GI, or recorded gender.
- For all other insurance types, provider must advocate for the patient.

# Tailored Health Promotion Messages

- Describing the HPV vaccine as an ‘anticancer vaccine’
- Utilizing self-care and ‘if you have it, check it’ messages to promote screening
- Describing the benefits of weight reduction on health, longevity, and quality of life
- Avoiding use of heterosexualized and binary-gendered symbols (e.g., pink-ribbon, red dress) in screening campaigns





Bare it all





- *Bare It All* encourages LGBTQ New Yorkers to talk openly to their doctors about their sex lives and other issues that affect their health.
- This campaign aims to empower LGBTQ New Yorkers to find a new doctor if they don't feel comfortable having these frank discussions with their current one.
- To help New Yorkers find LGBTQ-knowledgeable providers, the Health Department created a directory of over 100 health care facilities that provide primary care services, sexual health services, gender-affirming care and HIV services, many of which includes facilities that offer care regardless of documentation or access to health insurance



# NYC Health Map

Provider finder tool that allows patients locate LGBTQ-knowledgeable health care providers in NYC

**NYC** Health

311 | Search all NYC.gov websites

Promoting and Protecting the City's Health

**NYC** HealthMap

Español | Text-Size


NYC Center

2 results found for the selected service.

Montefiore Children's Hospital - Adolescent AIDS Program  
3514 Wayne Avenue, Bronx, New York 10467

Mount Sinai - Adolescent Health Center  
312-320 East 94th Street, Manhattan, New York 10128

GENDER AFFIRMING CARE



NYC HealthMap | v0.1.0.1 Beta

Directory of City Agencies

Notify NYC

NYC Mobile Apps

Contact NYC Government

CityStore

Maps

City Employees

Stay Connected

Resident Toolkit

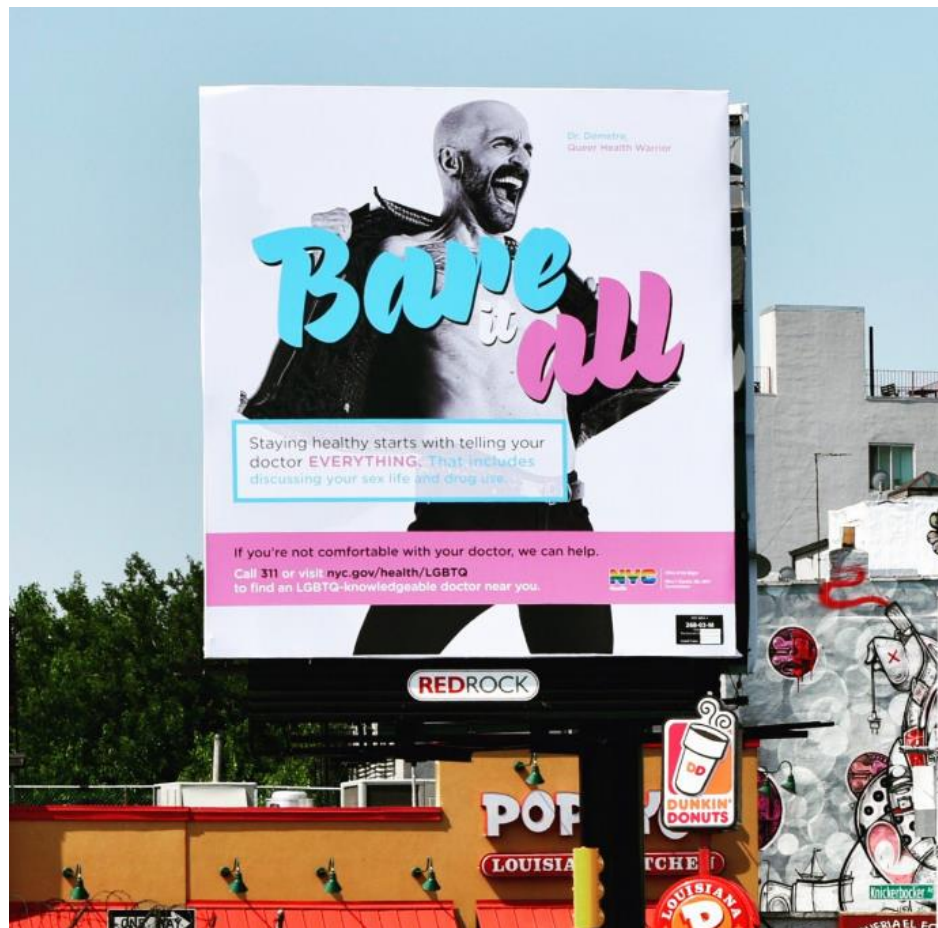
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Bare it all





# Bare <sup>it</sup> all



# Bare <sup>it</sup> all

**NYC**  
Health

Bare  
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all

[\[English video\]](#)



IF YOU'RE NOT COMFORTABLE WITH YOUR DOCTOR, WE CAN HELP.

Call **311** or visit [nyc.gov/health/LGBTQ](https://nyc.gov/health/LGBTQ)  
to find an LGBTQ-knowledgeable provider near you.

 Office of the Mayor  
Mayo T. Rivera, MD, MPH  
Commissioner

[\[Spanish video\]](#)



SI NO TE SIENTES CÓMODO CON TU MÉDICO, TE PODEMOS AYUDAR.

Llama al **311** o visita [nyc.gov/health/LGBTQ](https://nyc.gov/health/LGBTQ) para encontrar  
cerca a un médico familiarizado con la comunidad LGBTQ.

 Oficina del Alcalde  
Mayo T. Rivera, MD, MPH  
Comisionado



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it  
all





# LBGTQ

## HEALTH CARE BILL OF RIGHTS

The logo features the letters 'L', 'G', 'B', 'T', and 'Q' in various colors (pink, blue, green, purple, orange) arranged in a row. Below them, the words 'HEALTH CARE' and 'BILL OF RIGHTS' are written in a bold, black, sans-serif font.

# HEALTH CARE BILL OF RIGHTS

- Developed as part of Health Department's efforts to advance health equity and wellness for NYC's LGBTQ communities
- Goal was to design a tool for both patients and providers to clearly define legal rights of LGBTQ New Yorkers within health care settings
- Makes LGBTQ New Yorkers more aware of their legal rights
- Empowers patients to seek health care that meets their needs
- If a patient feels they are being mistreated or denied the care they need, patients encouraged to find a new provider and file a complaint with the NYC Commission on Human Rights

## Poster

## Wallet Card

10. Privacy and confidentiality

# LGBT HEALTH CARE BILL OF RIGHTS

Mistreated or denied care because of your sexual orientation, gender identity or gender expression?  
Call 311 or 718-722-3131 to file a complaint with the New York City Commission on Human Rights.

For more information on your health care rights, visit [nyc.gov/health/LGBTQrights](https://nyc.gov/health/LGBTQrights).



Call 311 or 718-722-3131 to file a complaint with the New York City Commission on Human Rights.

For more information on your health care rights, visit [nyc.gov/health/LGBTQrights](https://nyc.gov/health/LGBTQrights).



1. Right to be treated with dignity, respect

*Bare  
it  
all*





# Conclusions

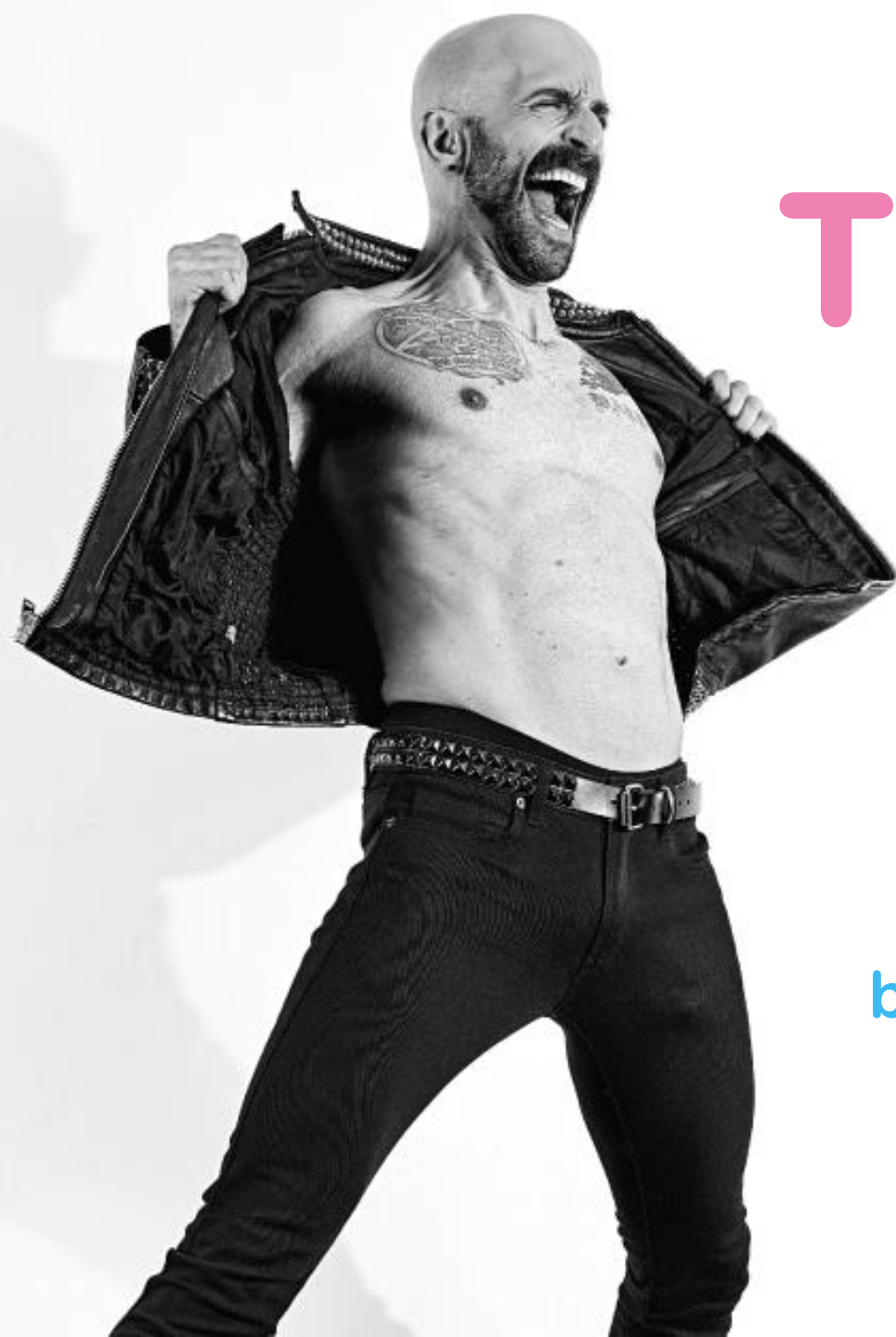
- LGBTQ people are diverse and risks will vary greatly.
- Some are at increased risk for adverse health outcomes because of biological, behavioral, social/structural issues.
- Screening and prevention recommendations should be based on population evidence for net benefit, an individual's unique risk profile, and presence of relevant anatomy.
- Expert consensus can be used to guide care when evidence specific to SGM populations is lacking.
- Early initiation of HAART and PrEP and anal Pap testing offer new opportunities to engage at risk persons and providers in STI diagnosis and disease control.
- Clinical approach should follow principles of trauma-informed care and focus on psychosocial comorbidities, harm reduction and development of resilience.



# Acknowledgments

- **Kenneth Mayer & Jenny Potter** from **The Fenway Institute** for allowing us to adapt “Comprehensive Preventive Health Care for Sexual and Gender Minority Patients”





# Thank you!

Questions?

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